A.M.

Maryland 21215-0036

JANUARY

JOHN ANTHONY,

> 5 State Registrar

31. Date filed (Month, Day, Year) 2008

TARIQ MAHMOOD, M.D.

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

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21093

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1253 **Physician** Armstrong 24 Ronald anuar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner maryland GAMERA 8. Date of Birth (Month, Day, Year, 3/3/1948 Country) Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Age (In vrs. last birthday **Funeral** Months Days Hours 1□M 2□F 63 Director 210-42-0311 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b County or 28a-f show e notified at 1 Yes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be not injury or other traumatic event, the Medical Examiner must be not injury or other traumatic event, the Medical Examiner must be not injury or other traumatic event, the Medical Examiner must be not injury or other traumatic event, the Medical Examiner must be not injury or other traumatic events. 21217 U.S.A 1640 Appleton ST. Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 24 ☐ No Specify: Black Specify. þ Baitimore, Maryland 21215-003 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 5 in and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) State Of Maryland Engineer NA NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Evelyn Α. Ligon Maurice Armstrong 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1640 Appleton ST. Baltimore, MD 21217 sition (Name of Date 20c. Location - City or Town, State Anita Coates<u>-Friend</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Arbutus MEM.Park | 1/30/08 Arbutus, MD 22. Name and Address of Facility M/FH East 1101 E. North Ave Baltimore, Md 21. Signature of Fun Al Service Licenses Brut Million. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 10 disease or condition resulting in death) /Medical Due to (or as a cons - ence of): Examiner remic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Unoma The law requires that the death certificate be executed the burial-transi al Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? (es 2 No death? 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Mannet of Death After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death, investigation ours after death. neral Director; A filled in by the fu 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours a To the Funeral I completely filled I 📝 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier.

State Registrar

31. Date filed (Month, Day, Year)

JAN 2 9

Tabatabacian, M.D. G.

30. Name and address of person who completed cause of death (Item 23a) (Type

ure

State of Maryland / Department of Health and Mental Hygiene) 02003 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Jan 24,2008 Artis 710pm William Leo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Clinton Clinton Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/14/1923 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 10 M 20 F 202-12-4475 Yrs. Pa Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ir than "natural", or items 23a or 28a-f show the Medical Examiner must be nutified at Prince George Forestville Md 1 Tyes 2 TNo **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20747 U.S.A. 1806 Berry Lane filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status GYes 2 □ No f Yes, Give 1 Never Married 2 N Married 1 ☐ Yes ŽÍŽNo Specity: Baltimore, Maryland 21215-0036 Specify: Black ģ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 2years Marines Military 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Leo Artis Unavailable ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1806 Berry La Forestville Md 20747 Jean Artis(wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington Nat'1 20c. Location - City or Town, State 20a. Method of Disposition 1 ™ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Va 1 4 ☐ Donation 5 ☐ Other (Specify) 02/07/2008 21. Signature Funeral Service 22. Name and Address of Facility any ir Lee Funeral Home
6633 Old Alexandria Ferry Way Clinton Md 20735 0 her the disease, or complications that caused the death. or heary failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1 Immediate Cause Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, y cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last attending physicien and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, should be c Completed by 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No page 2 s certificate 1 Yes 2,□,No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient ၉ 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after deat To the Funeral Director: filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide Uniformitying Rhyafcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 25/08 5214 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pt Washington MD LIVINGSTON YEA aine 70 avonno 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2008 (trua n au /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Essex Riverview Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (1911) Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min MD 1 ☐ M 2 🙀 F 96 Director 216-36-3562 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Rosedale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1517 Burnfield Road 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or item any injury or other traument. 1 Never Married 2 Married White 1 ☐ Yes 2 🖺 No Specify 9 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Drasal Amelia Levecek ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Diane Krysztofiak/Granddaughter 1517 Burnfield Rd. Rosedale MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/28/08 Most Holy Redeemer Baltimore 21. Signature of Funeral Service 22. Name and Address of Facility Schimunek Funeral Home Inc. Nottingham MD 21236 9705 Belair Rd. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final new roma week **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner sician and burial-transit the death certificate be executed resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 5 Other (specify) □Yes 2 No 9 Unknown 9 Unknown The law requires that Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>}</u> 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? derent 24a. Was an has autopsy performed certificate 2□ No 1 Yes 21110 1 ☐ Yes or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 100 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ဥ To the Hospital or ... within 24 hours after death.

To the Funeral Director: After thi funeral 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State Registrar 29b. Signature and title of certifier

30. Name and address of pers

Date filed (Month.

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in who completed cause of death (Item 23a) (Type, Print)

7310 200%. Registrar's Signature

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29c. License number

Zitelin try may \$508 Glen Bornie, Hd 2061

29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 1/2001

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3 1 an	tem 2 other		20a. Method of Dis			20b. F	Place of Disposemetery, cr	position (Na	me of	i	Date		cation - City or	
Page:	nt: If iry or			☐ Cremation 5 ☐ Other (Spe	3 □Removal from State ecify)	7	ornotory, or	cinatory or	ourer pra	1				
ermit.	Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of R	uneral Service Li Onald S	censee Din	ector	:	22. Name a State	<sup>nd Addre</sup> Ana	ss of Facility		W. Ba	ltimore	Street
	= a 0	7	23a, Partt, Enter	the disease, or c	omplications that cause	d the deat		Balti nter the mo				arrest,	1	Approximate Interval Between
Phy	sician		shock, or he Immediate Cause disease or condition	art failure. List o	nly one cause on each l	ine.		inte	rict	77	Imen	. ,	disens	Onset and Death
/M	edical		resulting in death)	on	Due to (or as	a conseq	uence of):	DOLL	1	117.1	11/4/6		CIIXIVA	
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or Atte	irecto n by th	Certification:	3☐ Suicide 4☐ Homicide	6 Could no determin		jury - At h	ome, farm, : fy)	street, facto	ry, office			(Street an own, State		ural Route Number,
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<b>5</b>	<b>C</b> 00	Σ	29b. Signature an	//	// /	D	0.			5442	4	1	te signed (Mont	08
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 7:48 PM 20 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and humber) **Examiner** aurel Regional Hospita Prince George's \_dure 8. Date of Birth (Month, Day, Year) Sept 19, 1 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗹 F Sept 1936 Maryland 71 Director 247-50-6832 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c, City, Town or Location 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2☐ No Director Harford Edgewood MD 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code USA 21040 1002 Magnolia Woods Lane #E Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: white þ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) social worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Holcolm Leonard Avery Cox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21075 7996 Millstream Court Elkridge, MD Lorraine Ward/daughter injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important: If any injury or 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Rona Ld S. Wade m 21201 Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in heart failure. List only one cause, in each line. Immediate Cau e (Final disease or condition resulting in death) **Physician** 500 Rus /Medical Due to (or is a consequence of): Examiner @lost Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobagco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 3 Probably 4 Unknown 2 □ No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has performe death? 1 ☐ Yes 2 □ M6 2 No director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2[]/No 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 27. Manper of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide e Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

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31. Date filed (Month, Day, Year)

32 Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jaewan Physician 5:30 2008 /Medical 4a. Facility Name (If not institution, give street and number) Jown, or Location of Death 4c. County of Death Examiner lledical aller ltima If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 219-32 Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medir a Examiner must be notifiled at Baltimore Director 1 No 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hrenue Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite mony injury or other traumatic event, the Medical Examine. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) gineer ather's Name (First, Middl 18. Mother's Name (First, Middle, Be Iam Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rujal Route Number, City or Town, State, Zip Code) Balto. , MD 21230 20a. Method of Disposition

1 Burial 2 Cremation 3 R
4 Donation 5 Other (Specify) 3 Removal from State 21. Sign ture of uneral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) acloudcarrinama **Physician** 3 Mouth /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate has autopsy performed? 2 🗌 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of eath 28a. Date of Injury 28b. Time of After t 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After (Month, Day Year) 5 Pending investigation 1 Natural Injun 1 ☐ Yes 2 ☐ No 2 ☐ Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print) ST. 30. Name 🖠 address of person who baltinere, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 2 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Christoria Boswell 6:05 A January 25, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Crofton Convalescence & Rehab. Center Anne Arundel Crofton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2√ F 214-28-7723 91 Maryland Director May 29, 1916 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at show 1 ☐ Yes 2√2 No Anne Arundel Gambrills Director Maryland Pages 1 and 2 should be filed within 72 hours after death with the I nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 7 21054-1934 U.S.A. 1378 Defense Highway Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Examiner 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced Year or Dates: er than "natur, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home ed other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joanna Kidwell James Oden McKenzie 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21054 1378 Defense Highway, Gambrills, Maryland James M. Boswell/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 kg Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery 1/28/2008 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, 101 the 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** lay neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Con chio Vasculon Diseas pertensive Sequentially list conditions, Examine ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical ast IF FEMALE: esn 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.0. ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown has been sig ge 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate ha autopsy performed 1□ Yes 2 🔀 Hospital or Attending Physician: uneral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Medical Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of eath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural (Month, Day Year, Injury 5 Pending s after death. 1 □ Yes 2 □ No investigation 2 Accident the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 24 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallant Fox Lane #222 Bowie, MD 20715 hakesh Aora, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 9 2008 Registrar

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MARYLAND 21204

M D 76.711 32. Pojistrar's Signature 08-00047 Glo

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lover C. Brown	1	State of Maryland / Department of Health and For State Amend Item 21 per fh, g875 if 01 if 29 / 08 in b		eg. No. 2008 020 1
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last) Glover C. Brown	2. Date of Dea Month January 2	Day Year
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or		4c. County of Death Prince George's
Funeral		Southern MD Hospital Clinton  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea	r If Under 24Hrs. 8. Date of Bir	rth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		219-42-4329 1X M 2 F 62 Yrs. Months Days	s Hours Min. Februa	ary 17   Country) 1945   Maryland
nd show any <u>cc.</u>		Usual Residence of Decedent  10a. State		10d. Inside City Limits 1 XYes 2 No
with the Maryland us 23a or 28a-f show be notified at once.	Director	10e. Street and Number 719 Barnes St NE 10f. Zip Code 20019	1	log. Citizen of What Country? U.S.A.
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Menial Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cubar	spanic Origin? ( Specify Yes or No n, Mexican, Puerto Rican, etc.)	White, etc.
ural",	<u>a</u>	3 Widowed 4 N Divorced If Yes, Give Year 1 Yes 2 No 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupar		Specify: Black  16b. Kind of Business/Industry
6 172 hou an "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	. DO NOT use retired)	Post and be
5-0036 led within 72 Hygiene, other than *	mo.	12 Laborer 17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle,	Private  Maiden Surname)
1215 De files ental Hy rrked o	Be	Evans Brown	Mary Rachel	Harrison
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	٩	19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street Tavonna Rochelle Brown 1341 Howard	et and Number or Rural Route Nu I Rd SE # 203	mber, City or Town, State, Zip Code)  Washington DC 2002
re, N s I and f Health fritem		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of ce crematory or other place)	metery, January	20c. Location - City or Town, State
altimore, mit. Pages I ar spartment of Hee portant: If ite		4 Donation 5 Other Specify: Chesapeak Crem		08 Beltsville Md
Bal permi Depar Impo				ilin Funeral Home shington DC 20020
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying failure. List only one cause on each line.		Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. <u>Hypertensive atherosclerotic cardial Due to (or as a consequence of):</u>	ovascular disease	Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
68760, certificate be executed mding physician and use as the burial - transit	Medical E	d.   X UNPENDED   AMENDED   1/20/09 FIII		
760, cate be physici the buri	/Med	##Z0a,Z/,penvic,go/J, 1/30/06 11    FFEMALE:   23c. If yes, outcome of pregnancy   23c. If yes, outcom		23d. Date of delivery
Box 6876  ne death certificate  the attending phy hed for use as the	cial	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 Other (Specify)	Ectopic pregnancy	Month Day Year
Records, P.O. Box The law requires that the death o cate has been signed by the atten page 2 should be detached for us	Physi	1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I. 23e. Did	tobacco use contribute to the cause of death?
ires that the signed by	5	,		es 2 No 3 Probably 4 V Unknown
of Vital Records, ig Physician: The law requir ther this certificate has been some and incertor, page 2 should I	Completed	<u> </u>	24a. Was	ppsy prior to completion of cause of
tal Recician: The la	Com		1 ✓ Yes	formed? death? 2 No 1 Yes 2 No
of Vital   ng Physician: .fter this certifi neral director,	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA	of Death (Check only one)  Other Nursing Home 5	Residence 6 Other:
C# _ \2	-1	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury 1	ury at Work? 28d. Describe	e how injury occurred
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office (Specify)	building, etc. 28f. Location or Town,	(Street and Number or Rural Route Number, City State)
To the Hosp within 24 hd To the Fun- completely i	Medical C	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinio and manner stated.	ate and place, and due to the caun, death occurred at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)
	ž	29b. Signature and title of certifier 29c. Licen	se number .M.E.	29d. Date signed (Month, Day, Year)  January 3, 2008
		30. Name and address of person who completed cause of death (Item 23a)	.IVI. L.,	Garidary 0, 2000
		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn S	treet, Baltimore, MD 212	01
St Regist		31. Date filed (Month, Day, Year)  AN 2 5 2008  32. Registrar's Signature		
DHMH 17 Rev 1/20	001	ORIGINAL		

To the Hospital or Attanding Physician: The law requires that the death certificate be executad Division of Vital Records, P.O. Box 68760 within 24 hours a

1 Ceruiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) H 53088 Crawyold January 28, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grane Tree #135 Baltimore Mg 21208 32. Angistrar's Signatu

D

29a. Certifier

Medical

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Thomas E. Berry /27/2008 2:10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1⊠M 2□F Months Days Hours Min Director 577-60-1448 93 6/20/1914 Washington, D.C Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □Yes 2 k No Director St. Mary's MD California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20619 U.S.A. 23140 Cobblestone Lane #410 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White δ Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OMB (Federal Govt.) Budget Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Grimes William Berry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3507 Lancer Dr., Hyattsville, MD 20782 Thomas W. Berry, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 1/29/2008 Alexandria, VA 21. Signator of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Respiratory Failure /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or injury Due to (or as a consequence of): Examine red by the attending physician and detached for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? res 2 🖾 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 X ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 🖾 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Division or Vital Records, P.O. Box 68760. death. or Attendated after death Director To the Hospital o within 24 hours aff To the Funeral D

10 Registrar

CAROLYN SPORN 31. Date filed (Month, Day, Year) State

Medical

4 Homicide

(Check only one)

29a. Certifier

29b.	Sign	ature and title of certifier		
	Þ	Caroly	Syon	MO

and manner stated

29c. License number D58461

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 08

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29

1500 Forest Glen Rd., Silver Spring, MD 20910

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 23, 2008 **Physician** 3:15 P Clyde Orville Bradley /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Olney Montgomery Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | February 27,1924 | Washington, D.C 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 3 M 2 □ F 577-26-8632 83 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c City Town or Location 10b. County 1 ☐ Yes 2 ☑ No Rockville Director Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20853 United States 13422 Dowlais Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Program Budget Officer Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia Dulaney Scott Chester Orville Bradley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13422 Dowlais Drive, Rockville, Maryland 20853 Alma M. Bradley/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn Memorial
Park January 28, 20a. Method of Disposition 20c. Location - City or Town, State 1 ➡Burial 2 □Cremation 3 □Removal from State Rockville, Maryland 4 Donation 5 Other (Specify) 2008 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licensee M01498 Lupa Logan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory /Medical Due to (of as a conse mince of): **Examiner** M Cardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (v) as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 | Yes 2 | No 3 | Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🔀 No 24a. Was an autopsy performed? 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number JANUARY 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Diney mb 20832 8101 Prince Dr. 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 21, 10:45 A M January 2008 Rosario M. Bea1 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Montgomery Hospice Casey House Rockville If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🕅 F 75 November 3. **Philippines** Director 577-86-6773 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Director Annandale Virginia Fairfax 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 22003 United States 8330 Glastonbury Court Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 X Yes 2 ☐ No Specify: Spaniard Specify: White þ 3 Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julita Diamante Luis Garcia Menendez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michelle B. Pappas /Daughter 12417 Rivers Edge Drive, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 1 
☐ Burial 2 ☐ Cremation 3 ☐Removal from State Arlington National Cemetery 5, 2008 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licensee M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pancreatic Cancer Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit and / Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2□No 1□ Yes director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: 2 ER/Outpatient 1 ☐ Yes 2X No 1 🔲 Inpatient 3□ DOA Certification: To this funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury After t Injury (Month, Day Year) 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3☐ Suicide 4 Homicide

P.O. Box 68760 Division or Vital Records, Hospital or Attending Physician: 24 hours after death. filled in by the within 24 hor To the Fune completely fi the

Baltimore, Maryland 21215-0036

Medical

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001 Muncaster Mill Road, Rockville, Maryland 20855 M.D. Genevieve Wroblewski,

🕻 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0064615

29d. Date signed (Month, Day, Year)

January 22, 2008

31. Date filed (Month, Day, Year)

nd title of certifier

29a. Certifier

29b. Signature



08-00528 Barry Bruce Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rry Bruce		1- For State	State of Maryla		ment of ficate of		Mental Hy		g. No. 2 1	08 02019
Physicia	an/	Registrar 1. Decedent's Name (First, Mid			-	<del></del>		2. Date of Death	Day Year	3. Time of Death
edical Exami	ner	BARRY R. B			1.4	b. City, Town, or Lo	parties of Death	January 18	3, 2008 4c. County of I	1748 hrs
		4a. Facility Name (if not institute 227 South Broadway		nber)	4	Baltimore	cation of Death		40. Southly of L	
Funeral Director		5. Social Security Number 214-84-5990	6. Sex	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year  Months Days	If Under 24Hrs. Hours Min.	8. Date of Birt 3/31/	h(MM/DD/YYYY) 1961	9. Birthplace (State or Foreign MARYLAND Country)
		Usual Residence of Decedent								
w any		10a. State 10b. Count	ty /A	10c. City, To	own or Location	on TIMORE CI	·TY			10d. Inside City Limits  1 Yes 2 No
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ms 23s	eral	11. Marital Status	12. Was Dece	edent Ever in U.S.		Decedent of Hispa es, specify Cuban, I			14. Race - White,	American Indian, Black, etc.
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72 hours after death with the Maryland n"matural", or items 23a or 28a-f she al Examiner must he notified at once	by	3 Widowed 4 D  15. Decedent's Education (S	Divorced If Yes, Give Year or Dates: pecify only highest grad		6a. Deceden	t's Usual Occupatio	n (Give kind of w		16b. Kind of Busin	ness/Industry
36 thin 72 hor ne. than "na edical Exs	Completed	Elementary/Secondary (0-1:	2) College (1-	-4 or 5+)	during mo	ost of working life. [	OO NOT use retir	ed)		
5-003 led withi Hygiene. other th	Som	12 17. Father's Name (First, Midd	_		ONLA				Maiden Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be (	WILLIAM BRU					MARY DO			
	To	19a. Informant's Name/Relatio				Address (Street QUEENSGAT				
e, M l and 2 Health item 2		20a. Method of Disposition			ace of Dispos ematory or oth	ition (Name of ceme	etery,	Date	20c. Location - C	City or Town, State
MOr Pages nent of ant: If		1 X Burial 2 Cremat 4 Donation 5 Other		om State MT	. ZION	CEMETER	Y 01/	<b>′</b> 29/08	LANSDOW	NE, MD
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other trauman		21. Signature of Funeral Servi		No.		lame and Address				ME 21207 TIMORE, MD
Physician		23a Cart I. Enter the disease,	or complications that ca	aused the death. I	Do not enter the	ne mode of dying, s	uch as cardiac o	r respiratory arr	est, shock, or hear	t Approximate Interval Between Onset and
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, amme.		or condition resulting in death	Due to (or as a	consequence of):						
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6876 certificate rding phy se as the l	sician/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	n the 1 Live b		2 Fe	tal death 3	Ectopic pregna	ancy	Month	Day Year
Box 6876( e death certificate the attending phy ed for use as the b	sici		Unknown 9 Unkno	ant at time of dea	<sup>th</sup> 5 01	her (Specify)			1	
O. B at the d I by the tached	/ Phys	Part II. Other significant con			sulting in the	underlying cause gi	ven in Part I.			oute to the cause of death?
S, P.O  Lires that the signed by dedetact	ed by			<del></del>				1	and the second	Probably 4 V Unknown  /ere autopsy findings available
Records, The law requirificate has been single page 2 should b	Completed		<u>.</u>					24a. Was auto	psy pr	rior to completion of cause of eath?
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<b>Tital</b> sician: is certi	B B	25. Was case referred to med examiner?	Ulas altala amo	Inpatient 2 I	ER/Outpatien		of Death (Check Other Nursin	ng Home 5	Residence 6	Other: Scene
of Vital ing Physician: After this certi funeral director	일	1 Yes 2 No 27. Manner of Death	28a. Date		28b. Time of		y at Work?	28d. Describe	how injury occurre	ed
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Division ratending or Attending rater death.  The safter death or Attending the form of th	ertification:	d	Could not be etermined (Specify)		me, farm, stre	et, factory, office bu	uilding, etc.	or Town,		er or Rural Route Number, City
Division Hospital or Atten 24 hours after death Funeral Director: tely filled in by the	၂ ပ	29a. Certifier 1 Certifying	p Physician: To the bes	st of my knowledg	e, death occu	rred at the time, da	te and place, and	due to the cau	se(s) and manner	as stated.
Division of Vital Records, P.O. Box 68760, within 24 bours after death certificate be executed within 24 bours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical E	Examiner: On the basis and manner s	of examination an	d/or investiga	tion, in my opinion,	death occurred	at the time, date	and place, and di	ue to the cause(s)
	ž	29b. Signature and title of cer	3			29c. License O.C.N			January 19	ed (Month, Day, Year)
•		30. Name and address of pers	S m7	se of death (Item	23a)	0.0.1			1 22.104.19	,
Ø/			son who completed cau stant Medical Exa			et, Baltimore, I	MD 21201			
	tate			egistrar's Signatur	e	1. 1				
Regis	strar	10N 2	9 2008	F						

DHMH 17 Rev 1/2001 OCME 2006 OCME A

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day 11:30 PM **Physician** 2008 25 dred /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3916 Baltimer dmonson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🗷 F 224-38-6633 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ZYes 2 No r 28a-f sh Baltimore Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? must be n USA 21229 Completed by Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after on nent of Health and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Black 3 ☑ Widowed 4 □ Divorced Year or Dates: "natural", ed other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Domestic Hone 84REWS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be is marked Watsox Velma Davi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GWYNN Oak, MO 21207 harlotte Dausty Donna 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 31/08 Ba Himore Park ina 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Vaucon C 8 728 iberty Rd. Approximate Interval Between Onset and Death 23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line.

Im Ediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 To the Hospital or Attending Physician: 'within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | → No 2 ER/Outpatient 3 DOA ٩ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation within 24 hours area.

To the Funeral Director: A 1 TYes 2 TNo 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the fime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

2/25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Roselyn Bagatti Jan 27, 2008 3:30 p.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Anne Arundel** Laurel 3523 Pineywoods Place Apt 202 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2XF Hours Director 213-50-9350 66 **England** Nov 7, 1941 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits 28a-f show notified at 1 ☐ Yes 2 No Director MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 3523 PineyWoods Pl. Apt. 202 20724 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Guban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. 11. Marital Status filed within 72 hours after 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2000 þ Specify 4 Divorced White Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Advertising Rep. Advertising 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jean\_Brady 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4431 Manor Village Way Apt 114 Raleigh, NC 27612 Donna L. Bagatti daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Feb 01, 2008 All County Cremation Services. Sykesville, Maryland 21. Signature of Funeral Ser ce Lidensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lot as a consequence of Examine burial-transit death certificate be executed W Due to (or as a consequence of) Box 68760 physician Physician/Medical the as the attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. | 9 Unknown signed by table to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Ves 2 No t⊟ Yes Division or Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1-Natural Injury 5 Pending investigation 1 Yes 2 No death. l or Attend after death. Director: A 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours at To the Funeral crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) s of person who completed cause of death (Iten (0 31. Date filed (Month, Day, Year) State 29 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Physician /Medical **Examiner Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

For State		State of	f Marylan		artmen <i>rtificati</i>				lental H	_	-2.0	0.8	2 0	202
Registrar     Decedent's Nam	o (First Middl	o last)			lillicati	e oi L	Jean		2. Date of D	Reg. N	10. C. U	00		e of Death
1. Decedent's Nam	ie (i iist, iviidai		e Baile	ev					Month		<sub>ay</sub> 24, 200	Year <b>R</b>		6:09 A <sup>N</sup>
4a. Facility Name (/	If not institution	n, give street and nur			4b. City,	Town, or	Location	of Death			lc. County			
	Gilchr	ist Hospice C	enter				To	wson				Ва	ltimore	)
5. Social Security N	lumber	6. Sex 1 □ M 2 🗶 F	7. Age (In yrs.		If Under Months	1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of B	irth ay, Yea	ır)	9. Birth	nplace (Sta	te or Foreig
227-48- Usual Residence of			73	3 Yrs.					June 1	3,10	934			Virginia
10a. State	10b. County		10c. Cit	y, Town or Lo	ocation								10d. Insid	e City Limit
MD		Howard					Col	lumbia	ì				1 🗆 🗅	res 2 No
10e. Street and Nu	mber				10f. Zip	Code				10g. (	Citizen of V	Vhat Co	untry?	
9502 Goo	d Lion Re	oad					21	1045						_
11. Marital Status		Armed Fo	dent Ever in U	.S. 13.	Was Deced If Yes, spec	dent of His	spanic O n, Mexica	rigin? (Sp an, Puerto	ecify Yes or No Rican, etc.)	0-		e - Amer k, White	rican Indiar , etc.	١,
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		nt's Education	atos.	16a. Dece	dent's Usua	al Occupa	ation			16b.	Kind of Bu	usiness/l	ndustry	
(Spec		st grade completed) College (1	-4or 5+)	(Give life.	kind of wor DO NOT us	rk done d se retired	luring mo )	st of worl	king					
Liementary/ Cook	maily (0 /L)	5	+		Gı	uidand	e Cou	ınselo	r			Edu	cation	
17. Father's Name	(First, Middle,	Last)					18. Moth	ner's Nam	e (First, Middl	e, Maid	en Surnan	10)		
			. Stubbs								an Hov			
19a. Informant's N	ame/Relations	ship (Type. Print)			_				ral Route Num			State, Z	ip Code)	
John Ba 20a. Method of Disp		2600	20b. F	950 Place of Dispo			Road	Colu	mbia, MD	, ,		City or	Fown, State	
1 ☐ Burial 2	remation	3 ☐Removal from	1 /	cemetery, cre	matory or o	ther place	1	1 0	:	200.		-		
4 ☐ Donation  21. Signature of Fu					iew Cre 2. Name an			lity	5-08			Baitin	nore, N	טו
Melon	1: MA	10 AND	itun	1703				•	P.A. like Ellicot					
23a. Part1. Enter t	the disease, or	r complications that c	aused the deat	h. Do not en							MD 210	043	Approxi	mate
Immediate Cause	(Final	only one cause on e	ach line.	1111	con	VPI							Onset a	Between and Death
disease or conditio resulting in death)	on	a. Due to	or as a conseq	uence of):	CON	ur							mer	uns
				,										
Sequentially list co if any, leading to in cause. Enter Unde	enditions,	b. Due to (	or as a consec	uanea offy										
if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	injury	с												
resulting in death) l	Last	Due to (	or as a conseq	uence of):										
		d												
IF FEMALE:		23c. If yes, out	come of proces	anov.										
23b. Was deceden in the past 12 1 ☐ Yes 2.		1 ☐ Live b	irth 2 Feta	ıl death 3[	□Ectopic pr □ Other <i>(sp</i>						23d. Da Mo	te of deli nth	very Day	Year
1 □ Yes 2 9 □ Unknown	No	9□Unkno		ieaui 5	Other (sp	ecily)								
Part II. Other signi	ficant conditi	ons contributing to de	eath but not res	ulting in the u	ınderlying c	ause give	n in Part	I.	23e. Did	tobacc	use cont	ribute to	the cause	of death?
			· - · · · · · · · · · · · · · · · · · ·						1	] Yes	2 No	3 ☐ Pro	obably 4	Unknow
									24a. Wa		24b.	Were au	topsy findii	ngs availabl
									aut per 1∏ Yes	opsy formed′ 2 ☑ I	?   :	prior to d death? 1 □ Yes	2 \Box	of cause of
25. Was case refer	rred to medica	ıt [					26. Plac	e of Dea	th (Check only	- N	10		20110	
examiner? 1 ☐ Yes 2	)No	Hospital: 1 ☐ I	npatient 2	ER/Outpatier	nt 3 DC	Othe	er: 4□ N	lursing H	ome 5□Re	sidence	6) Opth	er (Spec	ity) 1/25	pile
27. Manner of Deat	th 5 ☐ Pendir	28a. Date	of Injury th, Day Year)	28b. Time o Injury	of 2	28c. Injury Work	at ?		28d. Describe	how in	jyry occur	red	100	1
2 Accident	investi	gation			М		∕es 2[	]No						
3 ☐ Suicide 4 ☐ Homicide	determ	ained   20e. Place	of injury - At hong, etc. (Specif	ome, farm, sti (y)	reet, factory	y, office			28f. Location City or To			er or Ru	ral Route I	Vumber,
OOA Cariffe	- I Carlotte	ng Dhysisian: To the	host of mile	uniodes de l	th accurred	at the 4	no dot-	and alse	and due 4= 11		(a) and ::		-4-14	
29a. Certifier (Check only one)		ng Physician: To the Examiner: On the band man												se(s)
29b. Signature and	title of certifie		ior didicul.		290	c. License	number			29d. [	Date signe	d (Monti	n, Day, Yea	ır)
MA10	1 Al	lun			7	75	9:	303	3	¿ ) A	MUAN	24	242	008
30 Name and add	ress of nerson	who completed caus	e of death (Iten	n 23a) (Tyne	Print)		0	-	3			,		
AAC	N/I C	HARIVES V	NO 6	701/	V.C	MAR	Les	ST	-LON	5	NO	2	405	_
31. Date filed (Mon	ith, Day, Year)	2008 32	egistrar's Signa	tine .	and I									

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 2 Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

To Be Completed by Funeral Director

JANE BAILEY JAN 24, 2008 0609

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day

DHMH 17 Rev 1/2001

Registrar

JAN 2 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Lois Mae Cover JANU, ARY 1811 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/a SAINT AGNES IfOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 81 Yrs. 5 Social Security Number 6 Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🕅 F **Director** 213-20-6721 05/27/1926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21227 1239 Ten Oaks Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White ģ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Real Estate d 2 should be filed w h and Mental Hygie 7 is marked other tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Aldridge Simpson Alice Lee Barnes or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum Gary W. Cover / son 1239 Ten Oaks Rd Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Crema 3 □RenAoval from State Lakeview Memorial Park 01/28/2008 Sykesville, MD 4 □ □ Onation 5 Other (Specify) 22. Name and Address of Facility  $Ambrose \;\; Funeral \;\; Home, \;\; Inc.$ neral Se vice Licens 21. Signatur 1328 Sulphur Spring Rd Arbutus, Maryland 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS how **Physician** 24 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BOWEL ISCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed siclan and burial-transi Due to (or as a consequence of): Box 68760. Physician/Medical use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant ed by the atten detached for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ğ 1 🗌 Yes 2 No 3 Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 1□ Yes 2 No 1 ☐ Yes 2 ☐ No Division or Vital in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 No 1 ☑ Inpatient 2 1 🗌 Yes 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C the Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

ER.

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pay, Year 9

THILLAIN ATHAN

32. Registrar's Signature

A Sales Allas

20800

S. Caton Ave

2008

MD 31259

State Registrar

31. Date filed (Month, Day,

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32. Begistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI

Year)

January

			1 - For State Registrar		/ Department of Health and N Certificate of Death	Mental Hygiene Reg. No.	008 02026
	Physici /Medi		1. Decedent's Name (First, Middle, Last	ie Lynn (	Carson	2. Date of Death Month Day JAN. 20	2005 3. Time of Death
	Examir Funeral Director	ner	090 10-0100	Ave.	4b. City, Town, or Location of Death  BAUT MORE  If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	1	ALT MORE  9. Birthplace (State or Foreign Country)  Tolecto, OH
	Maryland -f show	tor	Usual Residence of Decedent  10a. State  10b. County  At Time	10c. City,	Town or Location  BALTI MORE		10d. Inside City Limits 1 ☐ Yes 2 No
	h with the 23a or 28a at be not	Funeral Director	10e. Street and Number 2925 Manns	1	10f. Zip Code	10g. Citiza	en of What Country?
960	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show important: If item 27 is marked other than "natural", or items 23a or 28a-1 show all pinyl njury or other traumatic event, the Modified Examiliar russt be notified at ODGs.	by Funer	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		4. Race - American Indian, Black, White, etc. Specify: White
21215-0036	od within 72 ho giene. er then "natu , the Medical	Completed by	15. Decedent's Edi (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Lab Makag ER	MAR	d of Business/Industry EYLAND CK. TRAUMA
Maryland	nould be file 1 Mental Hy narked oth natic svsnt	To Be (	17. Father's Name (First, Middle, Last)  TACOD TO	seph Carso	n JANE	FT (40 th)	a Greene
	is 1 and 2 st of Health and item 27 Is n other treun		19a. Informant's Name/Relationship (T) 20a. Method of Disposition	n- brother 20b. Place	19b. Mailing Address (Street and Number or Rur  Ce of Disposition (Name of netery, crematory or other place)	1, Rome Cit	tion - City or Town, State
Baltimore	permit. Pages Depertment of Important: If it sny Injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens	Evans	- 101 1111 ,	The state of the	est Hill UD more MD 21234
	Physician /Medical Examiner		23a. Part1. Enter the disease, or emp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a Due to (or as a conseque	Do not enter the mode of dying, such as cardial concept;	Contract of the contract of th	Approximate Interval Between Onset and Death
3760,	ite be executed ysicien and he burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	10 Devenin		
P.O. Box 68	The law requires thet the death certifica ete has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal di 4 □ Pregnant at time of deal 9 □ Unknown	eath 3 Ectopic pregnancy		3d. Date of delivery Month Day Year
	quires thet in signed b uld be deta	ed by Pl	Part II. Other significant conditions co	ntributing to death but not resulti	ing in the underlying cause given in Part I.	23e. Did tobacco us	e contribute to the cause of death? No 3□ Probably 4 ÚUnknown
al Records,	: The law requir cete has been si . page 2 should	Completed by	Lease /	slingre	<u>~</u>	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
Vital	Physicism: this certificatal director, I	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EF	Othor	th (Check only one) ome 5 Residence 6	COther (Specify)
Division of	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		27. Manner of Death    Value   5   Pending investigation		8b. Time of Injury at Work?  M 1 Yes 2 No	28d. Describe how injury	
Divis	ital or Att rs after de al Direct led in by t	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At hom building, etc. (Specify)	ie, farm, street, factory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2   Medical Exami	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occurred at the time, date and place, in and/or investigation, in my opinion, death occur	red at the time, date and p	place, and due to the cause(s)
)	or Toon	2	29b. Signature and title by certifier	20	29c. License number	29d. Date	signed (Month, Day, Year)
	32		30. Name and address of person who	Stewart,	MION COM	· Cordin	Street
	Sta Registi		31. Date filed (Month, Day, Year)  JAN 2 9 20	32. Registrar's Signatur	l fossel	Ba14	On ecni-

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** C. Conner January 26,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3954 Link Avenue Baltimore Nottingham 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 🛣 F 218-40-0369 June 13,1942 Maryland Director 65 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Nottingham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3954 Link Avenue 21236 USA Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼No If Yes, Give 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🛛 No Specify. Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 vears Manager Sales permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Myers Sr. Alice Casey ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherri Ann Clark Daughter 3954 Link Avenue, Nottingham, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 1 ☐ Burlal 2 X Cremation 3 ☐ Removal from State Bayview Crematory 29, 2008 Baltimore City, MD. 4 Donation 5 Dother (Specify) Aignature of Funeral Service License Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease or complications that caused the death shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Metastahic Non Small /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2 No page 2 certificate has 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. Physician: death.

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

fter death

filled in by the To the Hospitaire within 24 hours of To the Funeral C completely filled in

State

31. Date filed (Month, Day, Year)

SIDASALUAM

29b. Signature and title of certifier

determined

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

30. I ame and address of person who completed cause of death (Item 23a) (Type, Print) Suite 208

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

lain

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Philadelphiaroad, Baltimore Mi

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Mary Annette Collard 1/23/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11011 Belton Street Upper Marlboro Prince George's If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 218 F Director 217-36-5133 68 11/4/1939 Washington, D.C Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show at ral", or items 23a or 28a-f sh Examiner must be notifled 1 ☐ Yes 2 No Director MD Prince George's Upper Marlboro 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11011 Belton Street 20774 U.S.A. by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or iter 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: 3 X Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy Security Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Curtis Truman Sales Mary Annette Fleshman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda A. Collard-Morton, Daughter 222 Painted Post Lane, North Potomac, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If its any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 1/29/2008 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Atherosclerotic Cardiovascular Heart Disease resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to for as a nonsequence of: cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed tran and Due to (or as a consequence of): burial-1 physician the buria Physician/Medical attending p use as IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) cate has been signed by the a page 2 should be detached 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3☐Probably 4☐Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performe this certificate 1□ Yes 2□No Physician: 25. Was case referred to medical examiner?
1☐ Yes 2☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1-Natural (Month, Day Year) 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760. P.O. I Division or Vital Records,

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

2 9

JAN

Registrar

DHMH 17 Rev 1/2001

300

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JAN 25 2008 11:00 P M VINCENT LOUIS CASSANI, JR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1X M 2□ F 1921 Massachusetts 86 Director 014-14-4259 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10h. County show 1 ☐ Yes 2 No r 28a-f sh Virginia Fairfax McLean Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number è e Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. USA 22102 ral", or Items 23a Examiner must b 1321 Titania Lane Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1X Yes 2 No 1940/ If Yes, Give Year or Dates: 1973 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White 3 ☑ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Captain U.S. Navy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theodora Bonzagni Vincent Louis Cassani ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i 9818 W. Park Village Dr., Tampa, Fl. 33626 Vincent Cassani/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot once. N Burial 2 ☐ Cremation 3 ☐ Removal from State 03/17/2008 Arlington, Virginia Arlington Natl Cem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Speature Funeral Service Licenses 171 W. Maple Ave. Va.22180 Money & King Funeral Home, Inc. Vienna, Milliott M00968 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARDIAL INFARCTION resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 I Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2□XNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐XNo 2 this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? After 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 28 Jan 2009 0101237003 (VA)

State

Registrar

TARA M. WALKER 31. Date filed (Month, Day, Year)

JAN 2 9 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LT

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** William James Craig, Jr. 01 2008 9:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 305 Burwood Avenue Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 10-30-1945 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral ™** M 2□ F 62 DE 221-28-8061 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits t be notified at 10b. County 1 ☐ Yes 2 No Director MD Glen Burnie Anne Arundel 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with Innent of Health and Mental Hygiene. 305 Burwood Avenue 21061 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or iten Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Credit Card Processing Program Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William James Craig, Sr. ပ Harriet Rebecca Alexander 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ellen E. Craig / Wife 305 Burwood Avenue Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Cremation 01-24-2008 4 ☐ Donation 5 ☐ Other (Specify) Stevensville, MD 22. Name and Address of FacilitSingleton Funeral & Cremation Srv 21. Signature of Funeral Service Licensee 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** uncer Years /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has e 2 autopsy performed? Yes 2 No s certificate ha death? 1 ☐ Yes 2 1 1 16 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Field Rolste A Glen Burnie Me 21061 31. Date filed (Month. Day. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 20, 2008 4c. County of Death A M JANUARY Charles Cooper 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death MARULAND GENERAL 5. Social Security Number 6. Sex 403p der 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) If Und 8. Date of Birth (Month, Day, Year) Jan 4, 1954 . Age (In yrs. last birthday) Months Days Hours unk 1**∑**M 2□ F 54 216-62-5159 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 X Yes 2 □ No Baltimore MD 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code USA 21217 401 W. Franklin Street 14 Race - American Indian. unk 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify black þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 827 Linden Avenue Baltimore, MD 21202 Maryland General Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify) in state 21. Signature of uneral Se e Licensee Ro S Wad 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street rector Baltimore, MĎ 21201 Approximate Interval Between Onset and Death 23a. art1. Enter the dial ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Immediate Cause (Final disease of emidition resulting in death) Que to (or s a consequence of): umonio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 NO 25. Was case referred to medical examiner? 26. Place o Be other: 4 ☐ Nurs 1 ☐ Yes 2 ☐ No

Examiner law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, attending physician the nse for the signed by page 2 should be certificate

Physician:

or Attending

Hospital

death.

within 24 hours after death To the Funeral Director:

After this

the

filled in by

completely

Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

items 23a or 2 iner must be n

o,

"natural"

than

permit. Pages 1 and 2 should be filed be Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, the any injury or other traumatic event, the second to the

**Physician** /Medical Director

Funeral

death with the Maryland

Baltimore, Maryland 21215-0036

Examiner funeral director, Certification: To

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

29h

lospital: 1 🔽 Inpatient	2 ER/Outpatient	3□ DOA	0
28a. Date of Injury	28b. Time of	28c.	In

1 ☑Inpatient 2 ☐	ER/Outpatient	3 🗆 🛭	OOA	O
Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c.	ln W

jury at /ork?

26. Place of Death Check on the										
other: 4 Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)									
jury at ′ork? □ Yes 2 □ No	28d. Describe how injury occurred									

6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Numb City or Town, State)
/		
1 Certifying Physi	cian: To the best of my knowledge, death occurred at the time, date and place	e, and due to the cause(s) and manner as stated.
2 ☐ Medical Examine	er: On the basis of examination and/or investigation, in my opinion, death occ	urred at the time, date and place, and due to the cause(s)

. Signature	and title of certifier		
	and title of certifier	$\mu$	Josh:

5 Pending investigation

29c, License number 603

29d. Date signed (Month, Day, Year)

State Registrar

C Maryland 10 2. Registrar's Signature 31. Date filed (Month, Day, Year) 2 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigati

and manner stated.

sant.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Inaymoud Leroy Davis

4a. Facility Name (If not institution, give street and number) 2:40PM 26.2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Date of Birth (Month, Day, Year) 2.13.1949 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 1 M 2 □ F Days Months 217-50-1667 50 Yrs. Director Usual Residence of Decedent 10c. Cify, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at by Funeral Director Baltimore 1 res 2 No 10e. Street and Number 10g, Citizen of What Country? 3812 Mary Avenue 21206 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 Ho If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 C No Specify. Specify: BIGCK 3 ☐ Widowed 4 ☐ Divorced Be Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Medical JOEC VISOR Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumatic event, once. other traumatic event. land 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iudg Davis/wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or To Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1.30.2008 Baltimore, MD Greenmount Cremator 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Cremation Services 21. Signature of Funeral Service License Vaughn C. There is ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5151 Baltimore National Pike Baltimore MD 21229 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter ordering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9□Unknown signed by ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ģ Division or Vital Records, llytion Avdiam 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No after death.

I Director: After this certificate has had in by the funeral director, page 2.0 autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hules St G BMC 6701 N.C 31. Date filed (Month, Day, 32. Bigistrar's Signature State Registrar

DHMH 17 Rev 1/2001

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 28, 200<sup>Yea</sup> **Physician** Bertha C. Davis 10:20AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2916 Virginia Avenue Baltimore N/A 8. Date of Birth (Month, Day, Year) June 24, 1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 X F 245-28-2899 94 1913 North Carolina Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. art: If item 27 is marked other than "natural", or items 23a or 28a-f show art: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Directo N/ABaltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2916 Virginia Avenue 21215 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Black Specify: Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Electric 12 Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Moddess UNK. 2 James Clav 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stokes Johnson, Nephew 2916 Virginia Avenue Baltimore, Maryland 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of himportant: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/29/08 Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician asmo Malignant /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): as IE FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? for Month Day 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 No certificate ha funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manger of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 1 Natural 5 Pending after death.

I Director: Al 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, or Attending Physician: within 24 hours aft To the Funeral D completely filled in

Baltimore, Maryland 21215-0036

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signature and title of certific

29d. Date signed (Month, Day, Year)

28,2008

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

005333

ORIGINAL

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** dder Danuary 2 W15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Perring 6. Sex Hackne Parkulle Balhour | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (St. Months | Days | Hours | Min. | Sept. 13,1922 | Virginia 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months 1 XM 2 ☐ F 226-24-4826 85 Yrs. Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 USA 7936 Belridge Road Apt. H Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☐ No Specity: Specity: þ 3 ☐ Widowed 4 ☐ Divorced Completed traumatic event, the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education (Specity only highest grade completed) 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within in Hygiene. Stewart Mitchell Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 12 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important: If Item 27 Is marked other: any Injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruby Elizabeth Connock Frederick Jacob Dedder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Stogdill-Girlfriend 5408 Grindon Avenue-Baltimore, Maryland 21214 20b. Place of Disposition (Name of cemetery, crematory or other place Beaverdam Baptist Church Cemetery Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Jan.30,2008 Troy, Virginia 4 Donation 5 Dother (Specity) 21. Signature of Funeral Service Licensee Name and Address of Facility 8800 Harford Road EVANS FUNERAL AND CREMATION Mr. Fudd Parkville,MD 21234 \_condrae 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** thrive 40 disease or condition resulting in death) + ailsre restis /Medical Due to (or as a consequence of): Examiner anoversia weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine A and death certificate be executed burial-transit adeno car cenom markles Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specity) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 ☐ Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Iston or Vital Records, 2 Chronic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No g nemia 24a. Was an has performed' this certificate or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Inversing Home 5 Residence 6 Other (Specity) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours a 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 31295 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinte 4202 6201 N Charles SA Werd Klees 31. Date filed (Month, Day, Year) Tousin mil 21204 Kloesz

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

				For Amend Item	State of Mary 1 per dr., g8	yland / 3 <b>75,0</b>	Department of 1/29/08dbb of	Health <i>Death</i>	and Mei	ntal Hygi Re	ene g. N2	08	02036	
	8	Physicia	270	1. Decedent's Name (First, Middle,	hona Dorf		RHONA			Date of Death Month NUARY	Day	2008	3. Time of Death	
/Medical Examiner			40	4a. Facility Name (If not institution, S	ion, give street and number) KESVILLE HEALTH CT		4b. City, Town, or Location of Death					ty of Death		
		Funeral Director		5. Social Security Number 215–30–8943	1 T 1 2 T 1	n yrs. last	yrs. If Under 1 Yea Months Days		r 24 Hrs. 8. Min.	Date of Birth (Month, Day, L0/08/1	<sup>Year)</sup> 931	9. Birthp Coun	lace (State or Foreign try) MD	
	aryland 2	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  The the stand Mental Hygiene.  The marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show item 77 is marked other than "natural", or items 23a or 28a-f show item 77 is marked other than Medical Examiner must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  MD BA	ALTIMORE 10	Oc. City, To	own or Location OWINGS	MILLS				1	0d. Inside City Limits 1	
				Oe. Street and Number			10f. Zip Code 21117				10g. Citizen of What Country?			
Ç				11 ROMNEY COURT  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 💢 No	Hispanic O ban, Mexica	rigin? (Specifi an, Puerto Ric	y Yes or No- an, etc.)	14. R	ace - Americ lack, White, cify: WHI	etc.	
				15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 5+		16	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  REALTOR				16b. Kind of Business/Industry  REAL ESTATE			
7				17. Father's Name ( <i>First, Middle, La</i>			POLLACK	18. Moth	ner's Name (F	First, Middle, M	faiden Surn			
				19a. Informant's Name/Relationship			9b. Mailing Address (Stree			Route Number,		n, State, Zip		
	more,	Pages 1 an nent of Heal nt: If item 2 iry or other		20a. Method of Disposition  1	B ☐Removal from State	20b. Place	e of Disposition (Name of etery, crematory or other pl	ace)	Date		20c. Location	ORE, M		
2	Balti	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Foneral Service Linensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208										
Į.	*	Physician /Medical Examiner		23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate use (Final disease or condition resulting in death)	on plications that caused the cause on each line.  a	STAC	SE DEN		s cardiac or r		est,		Approximate Interval Between Onset and Death	
12:30PM	8760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, it any, leading to limited at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a consequence of):								
2/08			by Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)							23d. Date of delivery Month Day Year		
7	rds, r		d by P	Take in Gallot Significant School and the second school and the se								o use contribute to the cause of death?  2 No 3 Probably		
X:	or Vital Record	e law has b je 2 si	Completed							24a. Was ar autops perform	y	prior to co death?	opsy findings available impletion of cause of	
RHON	Vital	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certific lely filled in by the funeral director,	To Be C	25. Was case referred to medical examiner?  1   Yes   2   No										
不不	Jivision o		Medical Certification:	3 Suicide 6 Could no	Pending investigation  □ Could not be determined  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  1 □ Yes 2 □ No  28d. Describe how injury occurred  28d. Describe how injury occurred						al Route Number,			
Ž'	Hospital		ical Ce	29a. Certifier  (Check only one)  29a. Certifier  29a. Certifier  (Check only one)  29a. Certifier  29a. Certifier										
_		To the within 2 To the complet	Med	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)							Day, Year)			
	6	12)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
		Stat Registra		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Lendcll R-Awlene MJ 6565N. Charles St Sufe 2007/Bcolto MD 21204  31. Date filed (Month, Day, Year)  JAN 2 9 2008  32. Registrar's Signature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Li Dou 27, 2008 4c. County of Death January 3:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8210 Tuckerman Lane Montgomery Potomac If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🔀 F Yrs. 216-31-4487 44 Director April 22, 1963 China Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10d, Inside City Limits 1 ☐ Yes 2 1 No Directo Maryland Montgomery Potomac 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or 8210 Tuckerman Lane 20854 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar", or items 23s any injury or other traumatic event, the Medical Examiner must United States Funeral . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Asian Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Acupuncturist Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P Huaizhang Dou Pulin Liu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Guang Chen / Husband 8210 Tuckerman Ln., Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Feb. 2, 2008 Bethesda, Maryland 21. Signature of Funeral Sovice Legee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M00896 7557 Wisconsin Ave., Bethesda, MD 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** years Lung cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 1 X Natural

burial-transit and The law requires that the death certificate be exe P.O. Box 68760. physician the as attending nse for signed by the a d be detached for Division or Vital Records. s certificate has be lirector, page 2 s or Attending Physician: funeral director. After this Hospital

with the Maryland

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: /

5 Pending investigation 2 Accident 3□ Suicide 4 ☐ Homicide

6 Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

January

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapner stated. 29c. License number

D0023600

🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., 5530 Wisconsin Ave., #1125, Chevy Chase, MD 20815 Bruce R. Kressel,

31. Date filed (Month, Day, Year) State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

JAN 29



Registrar

To the I

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

08-00266 Herbert Dailey

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 02040 Certificate of Death Rea. No. 1- For State Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day January 9, 2008 Physician/ 1432 hrs ' Examiner Herbert Dailey 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 1300 Washington Blvd. Apt. 6 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or unk If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 111 6. Sex oreign **Funeral** Months Hours Apr 4, 1945 Country) 62 Director 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits Oc. City, Town or Location any 10a. State 10b County Yes 2 No Baltimore 28a-f show notified at once, 10g. Citizen of What Country? Director 10f. Zip Code 10e, Street and Number 21223 USA 1300 Washington Blvd 14. Race - American Indian, Black, 23a 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12. Was Decedent Ever in U.S. unk Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. must be 1 Armed Forces? 1 Never Married 2 Married <sub>No</sub>unk Yes Specify: white Yes 2 X No specify: If Yes, Give Year 4 Divorced Widowed marked other than "natural", event, the Medical Examiner 16a. Decedent's Usual Occupation (Give kind of work done  ${
m unk}$  16b. Kind of Business/Industry unk ð 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) es 1 and 2 should be filed within 72 l of Health and Mental Hygiene 21215-0036 unk 18.Mother's Name (First, Middle, Maiden Surname) unk unk 17. Father's Name (First, Middle, Last) marked Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 111 Penn Street Baltimore, MD item 27 is Baltimore, MD O.C.M.E. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Ξ Important: injury or oth Donation 5 X Other Specify: in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Se ce Licensee Ronald S Ronaid Raltimore MD 21201

Prt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician Death fature. List only one cause on each line. **ledical** a. Cocaine and narcotic intoxication Immedia C use (Final disease ∡aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last pur Physician/Medical #23a.27 X UNPENDED perME\_9875\_1/30/08\_TT attending physician or use as the burial The law requires that the death certificate be 23d. Date of delivery Box 68760, IF FEMALE: Year Month Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown q Unknown ned by the a detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>P</u> Yes 2 No 3 Probably 4 ✔ Unknown ð 24b. Were autopsy findings available Completed 24a. Was an Division of Vital Records. prior to completion of cause of autopsy death? has Yes 2 V No 2 No certificate 26.Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical Be Other: Nursing Home 5 Residence 6 Other: Scene Hospital: 1 ER/Outpatient 3 Inpatient 2 this 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year 27. Manner of Death After Certification: 1 Yes 2 No Natura<sup>1</sup> Director: Fnd 1/9/2008 Fnd 215 pm hours after death 28f. Location (Street and Number or Rural Route Number, City Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) MD 1300 Washington Blvd. Apt 6 Baltimore, 6 X Could not be Suicide within 24 hours a. To the Funeral D determined House Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 10, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Southall, MD 32. Régistrar's Signature 31. Date filed (Month, Day, Year)

State

Registra

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State	State of Maryla		artment of H rtificate of		d Mental Hy	giene		
			Registrar		Cei	rillicate of	Deam		Reg. No.	A A A	0201
	Physici		Decedent's Name (First, Middle, La Bernadette Duckett	· ·				2. Date of De Month	Day	Year 2003	1703 PM
	/Media		4a. Facility Name (If not institution, given	ve street and number)		4b. City, Town, o	r Location of D		4c. Cou	nty of Death	1
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Г	Funeral		5. Social Security Number 6. 5	Sex 7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days		Irs. 8. Date of Bird (Month, Da	th v. Year)	9. Birthpl	lace (State or Foreign try)
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	P .		Usual Residence of Decedent	10- 0	ta. T					14	0d. Inside City Limits
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	death with the Maryland rms 23a or 28a-f show r must be notified at	al Dire	10e. Street and Number 6710 Ridge Road; Uni	it 101		10f. Zip Code	1237		10g. Citizen USA	of What Coun	try?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  Interportant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🔀 No	Hispanic Origin? an, Mexican, Pi Specify:	? (Specify Yes or No uerto Rican, etc.)	Afr	Race - America Black, White, or Cican America Bacify:	etc.
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Maryland 21215-0036	uld be filed fental Hyg rked othe tic event,	To Be C	17. Father's Name ( <i>First, Middle, Las</i> Herbert				18. Mother's	Name (First, Middle, Nancy I. D		name)	
Mary	nd 2 shou alth and M 27 Is mai r traumal		19a. Informant's Name/Relationship Darnell S. Williams		I .			r Rural Route Numb ore, Maryla			Code) t 101)
Baltimore,	s 1 a f He ftem item othe		20a. Method of Disposition		Place of Dispo	osition (Name of matory or other pla	cal	Date	20c. Locatio	on - City or To	wn, State
9	Page ento nt: if ny or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			L Cemetery	· i	01/2008	Baltimor	e, Mary	land
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8760, ~	icate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):						
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Division or Vital Records,	Attending death. ctor: After y the funer	ication	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year)	Injury	M 1	rk? ]Yes 2∐No	28f. Location (	Street and Nu		il Route Number,
Ö	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Certification:	29a. Certifier 1 ✓ Certifying P	hysician: To the best of my ki	nowledge, deat	th occurred at the t	ime, date and p	City or To	wn, State) cause(s) and	l manner as si	tated.
	o the Ha vithin 24 h o the Fu ompletely	Medic	(Check only 2 Medical Exacone)  29b. Signature and title of certifier.	miner: On the basis of examinand manner stated.	nation and/or ir	29c. Licen		occurred at the time,		gned (Month,	
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	11		30. Name and address of person who	and 9000 FI	RANKLI	rint) n Squa	are	DR. Ba	LTimor	re m	d 21237
	Sta	ato.	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature						

DHMH 17 Rev 1/2001

Registrar

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Dixon Inde :53 PM 22 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltim University Mamland Medical Cent NIT. 07 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 6 Say 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Months Days 1 X M 2 □ F MD 213-19-0222 37 Nov. 29, 1970 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits Baltimore 1XXYes 2□No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 4324 Shamrock Avenue 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status African American 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 W Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) unk Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Brenda Lee Clyde G. Dixon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Hendrickson / Mother 4324 Shamrock Avenue: Baltimore, MD 21206 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 01/31/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mount Zion Cemetery 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signatule of Funeral Service Licensee 638 N. Gilmor Street; Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumo Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 is marked other the any Injury or other traumatic event, the jonce.

**Physician** 

/Medical

**Examiner** 

10a. State

Director

Funeral

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Completed

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Physician/Medical

Completed by

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Certification: To

Medical

**Funeral** 

Director

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

physician and street transit law requires that the death certificate be executed as attending p the signed by t d be detach has je 2 , page certificate Hospital or Attending Physician:

After this certification within 24 hours after death

To the Funeral Director:
completely filled in by the f

Division or Vital Records, P.O. Box 68760,

			-				1 ☐ Yes 2 ☐	No 3 Probably 4 Unknown
							24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medica	ı				26. Place of De	eath (6	Check only one)	
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27. Manner of Death 1 Alatural 5 □ Pendir 2 □ Accident investi	ıg	8a. Date of Injury (Month, Day Year)	28b. Time of Injury	28 M	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28	d. Describe how injury	occurred
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		an: To the best of my kno						and manner as stated. place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Jan

2008

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State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

South 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 17, Ethlyn Emmons 2008 January 1:15 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Catonsville Commons Catonsville Baltimore 8. Date of Birth (Month, Day, Year) Apr. 13, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 🔯 F 82 219-12-7075 1925 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 218 Rolling Brook Way 21228 United States Funeral Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Clinton Cooke Matilda E. Wockenfus ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 Rolling Brook Way, Catonsville, MD 21228 of Disposition (Name of Date 20c. Location - City or Town, State Adolphus Emmons III - Son 20b. Place of Disposition (Name of semetery, crematory or other place) Method of Disposition permit. Page Department o Important: If I Burial 2 Cremation 3 ☐Removal from State Loudon Park Cemetery 1-21-2008 4 Donation 5 ☐ Other (Specify) Baltimore, MD and Address of Facilit Ambrose Funeral Home, Inc. of Funeral Sa any in 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Advanced Dementia **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Each of carry graces (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician; The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ page 2 should be 2√2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an certificate has 1□ Yes 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: A Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 3□ DOA 1 🔲 Inpatient 2 ER/Outpatient Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 4 hours after death.
•uneral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hin 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 0 D0056414

State Registrar

DHMH 17 Rev 1/2001

dress of

person who completed cause of death (Item 23a) (Type, Print)

Jocelyn El-Sayed, 16 Fusting Avenue, Baltimore, MD 21228 te filed (Month, Day, Year) 2000 32 Registrar's Signature

		1 - State State Registrar	of Marylan		artment of H rtificate of L		R	eg. No 2008	
Physicia /Medic		1. Decedent's Name (First, Middle, Last) SHIRLEY JEAN ECKE	RT				2. Date of Deat Month JANUF	th RY 25, 20	3. Time of Death
Examin	- 1	4a. Facility Name (If not institution, give street and Saint Joseph Med	number) ical Ce	nter	4b. City, Town, or	Location of Death			h ltimore
Funeral Director	4	5. Social Security Number 220–36–2445 6. Sex	7. Age (In yrs. 65	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Sept. 26	, Year) 9. Bir Co , 1942 Mar	thplace (State or Foreign buntry) yland
/land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	ocation				10d. Inside City Limits
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Dallimor permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Line ee			22. Name and Addres	ss of FacilitMitc	hell-Wiede	efeld F.H. In re,Maryland 2	
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on or vital meding Physician: The land. After this certificate he funeral director, page	ပ္	1 ☐ Yes 2 No Hospital:	Inpatient 2			4 ☐ Nursing H		ence 6 Other (Sp	ecify)
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To the within To the comp!	Me	29b. Signature and title of certifier	~ 11		29c. Licens	e number		29d. Date signed (Mor	
		Degrammen & M	rella	, m-1	D4	1410	· ·	January &	2514,2008
12		30. Name and address of person who completed							
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day OS **Physician** Month 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center Parkville Baltimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Oay, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Director 219-32-4743 99 Yrs Germany 24, 1908 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itams 23a or 28a-1 show treumetic evant, the Medical Examiner must be notified at MD. Director Baltimore Parkville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. USA 21234 tiled within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Completed by 3 X Widowed 4 □ Divorced "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than At Home Elementary/Secondary (0-12) College (1-4or 5+) 8 Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be tand Mental I Walter Pfeil Nanny Bergmann 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an itam 27 ls Elizabeth Morosko/ Daughter 9817 Homeland Ave. Baltimore, MD. 21234 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If its
any injury or ott Parkwood Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 0 1/31 /08 Parkville, MD. 1 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Evans Funeral Chapel and Cremation Services 8800 Harford Road Parkville, MD. 21234 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (FIT I **Physician** dise or condition resulting in death) MCUMONIO /Medical Due to (or as a con equence of **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury To the Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 Yes 2 No 2. : After this certitica e tuneral director, r 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation M within 24 hours after death.

To the Funaral Diractor: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 T Homicide 29a. Certifier I 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h mes Bumutha

Registrar

State

31. Date filed (Month, Day, Year)

JAN 29

ORIGINAL

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Physician 2008 4:00 AM Jane B. Eierman January 21, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🔽 F Jan 1, 85 1923 Maryland Director 218-14-7010 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 ☐ Yes 2 No Director MD Baltimore Parkville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8810 Walther Blvd 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🎇 No Specify: Specify: white þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Stephen Barnitz Martha Snowden 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Greg Eierman/son 4628 Armley Point Norcross, GA 30092 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☑Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Ronald S. Wade, Director enny Baltimore, MĎ 21201 23a. Part1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) dominal rear **Physician** /Medical Due to (or es a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown cate has been signed by a page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Ş Q 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? res 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital: 1 Tes 2 No 2 ER/Outpatient 3 DOA sice 1 Inpatient Certification: To After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 21, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balts. M. 21208 ( 6701 32 Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

08-00325 Maxmillion Eszto

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State of Maryland / Department of Health and Mental Hygiene	2008	3 02
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Division	I or Attend after death. Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - building, etc. (S)		m, street, factory, off	ice	28f. Location ( City or To	(Street and Number o own, State)	or Rural Route Number,
	oital ours af		CO. Cartifica 1 Continues Black	ysician: To the best of my	knowledge	do ath occurred at th	ne time, date and place	and due to the	cause(s) and mann	er as stated
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 ☐ CertifyIng Phy (Check only 2 ☐ Medical Exam	niner: On the best of my and manner stated.	mination and	d/or investigation, in r	my opinion, death occ	urred at the time	, date and place, and	d due to the cause(s)
	To the vithin To the complete	₩.	29b. Signature and title of certifier	1.0.	·	290 Lio	ense number		29d. Date signed (I	Month, Day, Year)
			I all frother	2 juice	7 '		70005		JANUARY	27,2008
	0		29b. Signature and title of certifier  30. Name and address of person who decreased the second secon	completed cause of death	(Item 23a) (	Type, Pript)	le (4	Polts	and Zi	20/2
	10		11 H (C. (24)	32 Registrar's S	101	14. Colo		,, 0, 0		
	Sta Regist	ate rar	31. Ďate filed (Month, Day, Year)	08 American Strains	1	goods!				

DHMH 17 Rev 1/2001

08-00634 Nathan Patrick F	enc	Please Type or Print in Black Indelible  State of Maryland / Department			ible.	
		- For State Certificate			. No. 200	S Time of Death
Physicia Medical Examir	er	Decedent's Name (First, Middle,Last)     NATHAN PATRICK FENCHAK		Month January 22	Day Year , 2008	2215 hrs
		4a. Facility Name (if not institution, give street and number) Franklin Square Hospital	4b. City, Town, or Location of Rosedale	Death	4c. County of Death Baltimore Cour	nty
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 217 - 73 - 8608 1X M 2 F 2	Months Days Hours	1.0	7, 2005 Cou	
	ŀ	Usual Residence of Decedent	Yrs.	Dept 2	7, 2003	10d. Inside City Limits
nd show any ice.	_	10a. State 10b. County 10c. City, Town or L Maryland Baltimore County Overl				1 Yes 2 No
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 7422 Brookwood Avenue	10f. Zip Code 21236	10	g. Citizen of What Coun USA	try?
h with th	era		. Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican,		14. Race - Americ White, etc.	can Indian, Black,
fter deat	by Fun	1 Yes 2 X No	Yes 2 X No specify:		Specify: Wh	ite
2 hours a "natura		15. Decedent's Education (Specify only highest grade completed) 16a. Dece	edent's Usual Occupation (Give king most of working life, DO NOT u		16b. Kind of Business/Ir	ndustry
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medical	Completed	N/A	N/A	s Name (First, Middle, M	N/A	
215-( be filed intal Hyg riked oth	Be C	17. Father's Name (First, Middle, Last) Paul G. Fenchak	Na	adine	Gunnarso	
MD 21 ad 2 should 1 lith and Mer m 27 is mar	٩		ailing Address (Street and Numl ) Highland Avenu			
ore, Nes 1 and of Health If item her tran	1	1 X Burial 2 Cremation 3 Removal from State crematory	sposition (Name of cemetery, or other place)	Jan 26, 200	20c. Location - City or	
altimore, mit. Pages 1 ar ppartment of Hee pportant: If ite		21. Signature of Funeral Service Licensee	Valley Mem Gat	dens	TTHOUTUIL	·
m មួន ្ទី ឝ្វី ឝ្វី ឝ្វី ឝ្វី ឝ្វី ឝ្វី ឝ្វី ឝ្វ	Ц	Martin D. Lawson  23a. Part I. Enter the disease, or complications that caused the death. Do not er	6500 York Road	, Baltimore	, Maryland	21212 Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Asibyxia by hanging				Between Onset and Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			4-1	
cuted and transit		events resulting in death) Last  Due to (or as a consequence of):  d.				
50, te be exe tysician a	ledica	X UNPENDED AMENDED, #23a, 27, 28a-f, perME, s	g876, 2/11/08 TT		23d. Date of delivery	
Box 68760, e death certificate be the attending physic ed for use as the bur	cian/N	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic Other (Specify)	pregnancy		Day Year
). Box the death	Physician/Medical	1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in		nt I. 23e. Did to	bacco use contribute to	the cause of death?
ires that the signed by	Š			1Yes	2 No 3 Prob	100000000000000000000000000000000000000
of Vital Records, ng Physician: The law require this certificate has been signeral director, page 2 should the coordinates of t	Completed			24a. Was autop perfor	sy prior to death?	topsy findings available completion of cause of
al Recursitificate tor, page		25. Was case referred to medical	26.Place of Death	1 ✓ Yes (Check only one)	2 No 1 Y	es 2 No
f Vita Physicis er this ce	To Be	examiner? 1 Ves 2 No  Hospital: Inpatient 2 VER/Outpate 27. Manner of Death  28b. Tim	e of Injury 28c. Injury at Work		Residence 6 Other	<u> </u>
ion o tending leath. tor: Aft	ation:	1 Natural (Month, Day, Year)	:05 pm 1 Yes 2 X	No subject a	asphyxiated by	
Division tal or Attendii rrs after death. "al Director: /	Certification:	3 Suicide 6 Could not be determined (Specify) other scene	street, factory, office building, et	or Town S	Street and Number or Ru tate) okwood Ave. No	•
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner:On the basis of examination and/or inve	occurred at the time, date and pla stigation, in my opinion, death oc	ace, and due to the caus curred at the time, date	e(s) and manner as stat and place, and due to th	ed. e cause(s)
Tot Tot com	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo.	nth, Day, Year)
O.K.		30. Tame an Jaddress of person who completed cause of death (Item 23a)	O.C.M.E.		January 23, 200	
Lend.	į	Zabiullah Ali, M.D. Assistant Medical Examiner 111	Penn Street, Baltimore, N	MD 21201		
St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Redistrar's Signature	house			
DHMH 17 Rev 1/2	001	ORIG	INAL		DOME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** GLADYS JEANNETTE FEDERMAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ( None 8. Date of Birth (Month, Day, Year) June 24,1922 Birthplace (State or Foreign Country) curity Number 7. Age (In yrs. last birthday **Funeral** Months Days Hours Min 1 M 2 F 018-18-0313 85 Massachusetts Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show Yes 2 No notified Director Maryland | None Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 6116 BelAir Road 21206 USA items 23a must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XX Black, White, etc. 1 Never Married 2 Married ò 1 ☐ Yes XXNo Baltimore, Marylahd 21215-0036 Specify White Completed by 3 Widowed 4 Divorced Year or Dates: permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hydjene. Important: If Item 27 is marked other than "natuul any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Artist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Federman Lena Nottenburg ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille Azanow Sister Shirley Terrace Holbrook Massachusetts 02343 20a. Method of Disposition
1 ☐ Burial 202 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State GreenMount Crematory Jan 23,200B Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Se 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, of complications shock, or heart failure. List only one cause ter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed that initiated events resulting in death) Last as the burial-tra Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal deal 4□Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ed by the a 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 autopsy performed? 2 HO 1☐ Yes 2 No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Manner of eath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 5 ☐ Pending investigation Injury Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Fo the Hospital Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

3

31. Date filed (Month, Day, Year) 2008

32. Registrar's Signature

address of person who completed cause of death (Item 23a) Type

State of Maryland / Department of Health and Mental Hygiene UUS

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 11:54P<sup>M</sup> JANUARY 21, 2008 VALERIE DENISE FLETCHER /Medical 4c County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGES PRINCE GEORGES HOSPITAL CENTER CHEVERLY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
DEC. 27, 1 7. Age (In yrs. iast birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax **Funeral** Months 1□M 2XXF 1957 WASHINGTON, 50 **Director** 577 76 8337 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at XX Yes 2 No LANDOVER PRINCE GEORGES Direct 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 23a or 20785 UNITED STATES 3413 DODGE PARK ROAD deeth Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNNo If Yes, Give Year or Dates: within 72 hours after 1 □ Never Married 2 □ Married 6 1 ☐ Yes XX No Specify: Baltimore, Maryland 21215-0036 Specify: BLACK þ XX Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) P.G. COUNTY GOVERNMENT BUS DRIVER 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental int: If Item 27 is marked o FRANK EPPS BARBARA D. WILLIAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3413 DODGE PARK RD. LANDOVER, MD 20785 STEPHON FORTUNE / SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If any injury or page. METROPOLITAN CREMATORY 01/25/2008 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC.
4308 SUITLAND ROAD SUITLAND, MD 20746 21. Signature of Funeral Service Licensee D. CEV P.m.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, he k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONARY ARTERY DISEASE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DIABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physicien Completed by Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? o 4 Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably ▼▼Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PERIPHERAL VASCULAR DISEASE autopsy performed? res XX No page 2 s has 1 ☐ Yes 2 ☐ No END STAGE RENAL DISEASE 1 ☐ Yes certificate Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical miner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) XX DOA XX Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient ٩ this After thi funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: XXNatural Injury Attending 5 Pending aspitar ...
4 hours after dec. ...
--ral Director: After 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I XX Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D 21428 23/08 census 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEVERLY, MD 20784 3001 HOSPITAL DRIVE LINDA D. GREEN, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

29

a Disco

08-00749 Jonathan Farr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

iauiaii Faii			For State	Of Ivial yland / L		ate of De	eath		ا	Reg. No.	21	108 020
Physic	ian		egistrar . Decedent's Name (First, Middle,La	st)					2. Date of De Month	Day	Year	3. Time of Death 1530 hrs
edical Exan		er	Jonathan Edwa <u>r</u>	d Farr					January	27, 200	. County of Dea	
		4	a. Facility Name (if not institution, gi	ve street and number)			ity, Town, or Lo altimore	cation of Dea	atn		N/A	
			3729 Gough Street	17 400/1	n yrs. last bir		Under 1 Year	If Under 24H	rs. 8. Date of f	Birth(MM/	DD/YYYY) 9. I	Birthplace (State or
Funera			. Social Security Number 6. S			N	onths Days		lin. B/6/		IFor	eign Country) <b>Canada</b>
Directo	4		001 02 1000	XM 2 F	32	Yrs.		<u> </u>	6/0/	1973		
any	l		Isual Residence of Decedent  0a. State 10b. County	10	c. City, Towr	n or Location						10d. Inside City Limits
<b>*</b>	ان		MD N/A	1	Baltim	nore						1 X Yes 2 No
rylancia-f.sh		밁	0e. Street and Number			10	f. Zip Code			10g. Citi	izen of What C	ountry?
ith the Maryland 23a or 28a-f show	ed :	Director	1515 Covington S	±.			21 230				USA	
with t	oe no.		Marital Status	12. Was Decedent Ev	er in U.S.	13. Was De	ecedent of Hisp	anic Origin? (	Specify Yes or rto Rican, etc.)	No-	14. Race - An White, etc	nerican Indian, Black,
death or iten	must	Funeral	1 Never Married 2 Marrie	1 Yes 2 X	No				,		Specify: L	hite
after	I I	9-		or Dates:	1100		s 2 X No Isual Occupation		of work done	T16b.	Kind of Busine	
hours	Ехаш	<u> </u>	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+		during most	of working life.	DO NOT use	retired)			
36 iin 72 han	dica	E E	Elementary/Secondary (0-12)	+5		Banker				М	ortgage	. Co
d with	le Me	Completed	17. Father's Name (First, Middle, La	st)			1	8.Mother's Na	ame (First, Middl	e, Maider	n Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	i,	a	Ted Farr					Teres	a Zevst	off	O't Tour C	toto Zin Codo)
21 rould I	tic ev	ို	19a. Informant's Name/Relationship						or Rural Route I	number, v	NA	21 23D
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho	auma		Anna L. Farr / L	lite	20b. Place	ープリカーし e of Disposition	n (Name of cen	netery,	Date Date	20c	Location - Cit	and 21230 y or Town, State
of Heg	her tr	- 1	1 Burial 2 XCremation	Removal from State	e crem	atory or other	place)		/20 /200		N	Maryland
imore Pages 1 ment of F	or of		4 Donation 5 Other Spec	ify:	HITIT		v. Corp					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural".	injury		21. Signature of Funeral Service Lic	ensee		Ruc	k Towso	n Fune	owson, eral Hom	Mary e, I	1ano 21 nc. 10	204 150 York Road
Physicia	_		23a. Part I. Enter the disease, or co	mplications hat caused the	he death. Do	not enter the	mode of dying,	such as cardi	ac or respiratory	arrest, s	hock, or heart	Approximate Interval Between Onset and
techn	a	ļ	failure. List only one cause on	each line. a. Contact Gunshot								Death
.amin	er		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec								
			Sequentially list conditions,	b	monce of).							
		iner	if any, leading to immediate cause. Enter Underlying Cause.	Due to (or as a consect c.								
· J	<u>.</u>	Examin	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):							
and ecute	red for use as the burial - transit			d								
60, ate be ex shysician	ourial	Medical	UNPENDED		o of prognan	101/				- 1	23d. Date of de	livery
376( ificate	s the b		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	le of pregnan		death 3	Ectopic pr	regnancy		Month	Day Year
Box 687 death certificathe attending p	nse a	icia	past 12 months?	4 Pregnant at t	time of death	5 Othe	r (Specify)			-		
<b>Bo</b> le deat	led for	Physician/	1 Yes 2 No 9 Unkn	5 OHRHOWIT	but not resu	ilting in the unc	deriving cause	given in Part I	. 23e. l	Did tobac	co use contribu	ite to the cause of death?
P.O.	be detache		Part II. Other significant condition	ns contributing to death	Dat Hot rosa	and and and		•	1	Yes 2	<b>✓</b> No 3	Probably 4 Unknown
S, F quires en sig	ld be	Completed by								Was an	24b. We	ere autopsy findings available or to completion of cause of
cords. law requi	2 should	ple			-				_ 1	autopsy performed Yes 2 ❤	d? de	ath?  Yes 2 No
tal Rec ian: The l	page	S					26 Plac	e of Death (C	heck only one)	res 2	NO	163 2
tal ician:		Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	nt 2 El	R/Outpatient	-	104	Nursing Home	5 Res	sidence 6 🗸	Other: Scene
of Vit Physic er this	eral di	T0	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju	ry 2	8b. Time of Inj	ury 28c. Inj	ury at Work?	28d. Desc Subject	chot se	injury occurred	
on of adding Plant.	4	tion	1 Natural 5 Pendi			OUND: 1525 hrs	1	Yes 2 V N	10			
Division of Vital Records, ral or Attending Physician: The law requirement of the Internet After this certificate has been simproper.	n by th	Certification:		not be 28e. Place of In	jury - At hom	ne, farm, street	, factory, office	building, etc.	or To	warn State	a)	or Rural Route Number, Ci
Divisial of	filled in by	erti	4 Homicide deterr	nined (Specify) Tox					3729 Go	ugh Stre	et, Baltimore	
Hosp 24 ho	etely f		29a. Certifier 1 Certifying Ph	ysician: To the best of mainer: On the basis of exa	y knowledge	, death occurre	ed at the time, o	date and place on, death occu	e, and due to the irred at the time.	cause(s date and	) and manner a i place, and du	e to the cause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours and After this certificate has been signed by the attending physician and	completely	Medical		niner:On the basis of exa- and manner stated.	mmanon and			nse number				d (Month, Day, Year)
	v	Ź	29b. Signature and title of certifier	M. ODA.	m			.M.E.		- 1	January 28,	·
				Jeef M		(20)						
1	$\lambda$		30. Name and address of person Tasha Greenberg MD.		al Examir	ner 111 F	Penn Street	, Baltimore	e, MD 21201			
	`		5 - 1 - 1 - 1 - 1 - 5 - V1	4	ar's Signature							
		tate	IAN 2 9	2008	A.	0004	2					

State

Registrar

29b. Signature and title of certife

31. Date filed (Month, Day, Year)

776ND114

SAMPLITAN

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(00 DD

JAN 2 9 2008

29c. License number

HOSDITAZ.

30060039

DY MAN NAING OD

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 200 Sharon Fisher /Medical 4a. Facility Name (If got institution, give street and number City, Town, or Location of Death Examiner Baltimore HOSP NES N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Min. Maryland 1□ M 2 F Months Days Hours 219-40-4854 64 07/28/1943 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 Yes 2 No Maryland Baltimore N/A Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Department of Health and Mental Hygiene. Important; or Items 23a or Important: If Item 27 is marked other than "natural; or Items 23a or any Injury or other traumatic event, the Medical Examiner must be 1 once. 1913 Wilkens Avenue 21223 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify Specify: White 3 ☐ Widowed 4 ☑ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Fisher Gertrude Fitzpatrick ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Larry Bank / Personal Rep. 10634 Park Place Avenue Owings Mills, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State 1/26/2008 Baltimore, Maryland 4 Donation 5 Dother (Specify) Name and Address of Facility Hubbard Funeral Home, Inc. Baltimore, 21. Signature of Funeral Service Licensee Market 23a. Part1. Enter the disease. Homplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) year **Physician** non-small /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, backing the first class. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conse juence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2□ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, npatient 1 TYes 2 7 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t Natural 2 Accident 5 ☐ Pending investigation in 24 hours are: the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 29b. Signature and file of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

90

32. Rigistrar's Signature

DHMH 17 Rev 1/2001

Sharun Fisher

nave

23/08

BALTIMORE MO21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Januar Green /Medical 4c. County of Death 4b. City, Town, or Location of Death stitution, give street and number) Facility Name (If not Examiner Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Funeral Months 1 □ M 2 X F Yrs Director Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 XYes 2 No Funeral Director more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Completed by lar 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Print) (daughter) 19a. Informant's Name/Relationship (Type. 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State 21. Signature of Funeral Service Licenses North 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart vailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Schemic 1605 Oum and Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Suc to (or se a consequence of) Physician/Medical Examiner Hospital or Attending Physiclan; The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) funeral director, page 2 should be detached 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 17 No 3 Probably HYRECTENSION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2 ☑ No 2 PER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient Medical Certification: To 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? After 1 (Month, Day Year) 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 28 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNDEN

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For State Registrar	State of M	aryland / Dep	ertificate of L			ene 0 0 8	3 02057
			Decedent's Name (First, Middle, La	st)				2. Date of Death	1	3. Time of Death
	Physici: /Medic Examin	al	Barbara M. Girvi 4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Dea	01/24/2		11:30 AM
	<u> </u>	Ŭ.	Franklin Woods	Eldercare		Baltim	ore, Ma	ryland	Baltir	nore
	Funeral Director		5. Social Security Number 6. S	7. Ag ☐ M 2 <b>X</b> F	ge (In yrs. last birthda) 94 Yrs.	Months Days	If Under 24 H Hours Mi			Birthplace (State or Foreign Country) Maryland
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	_ocation				10d. Inside City Limits
	Maryli	ŏ	MD Baltim	ore	Kingsvi.	lle				1 ☐ Yes 21 No
	or death with the Marylan terns 23e or 28e-f show arrinual be notified at	Director	10e. Street and Number		_	10f. Zip Code		10	g. Citizen of Wha	at Country?
	23e c		11122 Sheradale			21087			U.S.A.	A document
36	hours after death with the Maryland tural', or tems 23e or 28e-f show al Exart art must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces  1  Yes 2  If Yes, Give Year or Dates:		. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No		(Specify Yes or No- erto Rican, etc.)	Specify:	American Indian, White, etc.
21215-0036	thin 72 hours afte e. an "natural", or t Medical Erant	ed b	15. Decedent's E	ducation	16a. Dec	edent's Usual Occup	ation		16b. Kind of Busin	White ness/Industry
215	within 72 ene. than "nat	Completed	(Specify only highest gri Etementary/Secondary (0-12)	ade completed) College (1-4or	life	re kind of work done of DO NOT use retired	during most of w	vorking		
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Maryland	a d la b y	Be	17. Father's Name (First, Middle, Last					M. Siebei		
ıry	d 2 should by th and Menta 7 is marked treumatic sy	To	Christian Lauba 19a. Informant's Name/Relationship		19b. Ma	iling Address (Street		Rural Route Number,		ate, Zip Code)
	5 = 0 -		Sam Girvin (so	n)	111:	22 Sherada	le Driv	e - Kings	ville, Ma	aryland 21087
ore,			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐		20b. Place of Dis	position (Name of rematory or other place		Date	20c. Location - Cit	ty or Town, State
Ë	nit. Pages artment of l ortent: If Its Injury or o		* 4 ☐ Donation 5 ☐ Other (Speci	fy)	Gardens (					e, Maryland
Baltimore,	permit. Pages Department of Importent: If If any Injury or once.		<u> </u>	assaln	)	11750 Bela	ir Road	l - Kingsv	ille, Mar	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause one cause on each	d the death. Do not e line.	enter the mode of dyin	ig, such as card	liac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		tmmediate Cause (Final disease or condition resulting in death)	a	RESPIRA	Ygorr	FAI	LURE		
	/Medical Examiner		resulting in doubly	,	s a consequence of):	065	AND	(000		
		- Le	Sequentially list conditions, if any, leading to immediate		s a consequence of):					
A.	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
٥,	sician and burial-transit		resulting in death) Last	Due to (or a	s a consequence of):					
68760,	cate b	dicai	•	d						
O. Box 6	ne death certificate be executed the attending physician and shed for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 SNo 9 □ Unknown		2 Fetal death	B Ectopic pregnancy Country Country	,		23d. Date of Month	
P.O	es that the de igned by the a be detached t		Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause giv	en in Part I.	23e. Did to	pacco use contrib	ute to the cause of death?
rds	quires in sign	ed by	C	AD,	ATRIA	L FC	B	_ 1 □ Y	es 2□No 3	Probably 4 Unknown
Records,	The law requires that the ste has been signed by th page 2 should be detache	Completed		/				24a. Was a autops perfore	ned? prid	ere autopsy findings available or to completion of cause of ath?  Yes 2 \sum No
Vital	ysiclen: The lis certificete ha	BeC	25. Was case referred to medical examiner?				1	Death (Check only on	e)	
of V	Physiclen: this certifice ral director, p	2	1 ☐ Yes 2 ☐ No	Hospital: 1 _ Inpat			4 Linursin	g Home 5 Reside	ence 6 Other	
	ding F	ton:	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of tn (Month, D	lay Year) 200. Tine	y Wo	rk?  Yes 2 □No	200. 2030/100 11	ow inquity obsumed	•
Division	I or Attendi after death. Director: A J in by the fu	fica	3 Suicide 6 Could not	28e. Place of I	niury - At home, farm,	street, factory, office		28f. Location (S City or Town		or Rural Route Number,
Div	s after s afte	Certification:	4 Homicide	building, (	etc. (Specify)			Only of Town	r, Diato)	
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical (	29a. Certifier (Check only one) Certifying P 2 Medical Exa	hysician: To the bes miner: On the basis and manners	st of my knowledge, de of examination and/or stated.	eath occurred at the till investigation, in my o	me, date and pl opinion, death o	ccurred at the time, o	ate and place, an	d due to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	)		29c. Licens			1	(Month, Day, Year)
•			from to	arshore			1000		1124	1 - 2
	if		30. Name and address of person who	completed cause of	death (Item 23a) (Typ	Print)	OUARE	DE B	ALTIM.	PE, MD.
	St	ate	31. Date filed (Month, Day, Year)	32 Regis	trar's Signature	A - 10 -		2.1)	( C	, ,
	Regist		JAN 29	2008	was At A	9242				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:17 P M 2008 Ruth Lillian Gruhn Jan. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Towson

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Baltimore Gilchrist Hospice Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🖾 F 85 Yrs. 516-20-1269 Director Feb. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2X No Director Baltimore Timonium 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 104 Oakway Road USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No White Baltimore, Maryland 21215-0036 Specify þ 3 N Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than the M College (1-4or 5+) Elementary/Secondary (0-12) p rmit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglen Important: If item 27 is marked other the any Injury or other traumatic event, the 12 Own Home N/A Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Lile Charles Dimmick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8110 Clyde Bank Baltimore, MD 21234 William D. Gruhn/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens Jan. 28, 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 21. Signature of Funeral Service License Lyll Maryan W. Inc. Clary 23a. Part1. E.n. rth disease, or complication, that caused the shock, in hear failure. List only one cause on earn line Approximate Interval Between Onset and Death sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate ause (Final disease or anditio resulting in emer **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 menths? Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2∐ No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours a To the Funeral C

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

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N-Charles St. Balto MJ 21208

Ki 31. Date filed (Month, Day,

32 Registrar's Signature

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State Registrar

Medical

			1 - For State Registrar	State of Maryl		artment of H rtificate of L		ind Ment	al Hygien Reg. N	2 U U	8 02059
	Physici	20	1. Decedent's Name (First, Middle, La	ast)					ate of Death onth Da	ay Ye	
	/Medic		Hilda M.	Greenwalt					ary 27,	2008	6:00 P M
7	Examin	er	4a. Facility Name (If not institution, gi			4b. City, Town, or			44	c. County of D	
			3301 Elmo Driv 5. Social Security Number 6.		yrs. last birthday)	Randal	ISTOWI		te of Birth	_Balti	MOTE Birthplace (State or Foreign
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			Usual Residence of Decedent				11	114845	2 00, 1	720 11	ar y rana
	yland		10a. State 10b. County	10c.	. City, Town or Lo	cation					10d. Inside City Limits
	a-f-	ctor	Maryland Balti	more	Randa]	llstown					1 Tyes 2 No
	ih th	Funeral Directo	10e. Street and Number			10f. Zip Code			10g. C	itizen of What	Country?
	23e	ral	3301 Elmo Drive			21133					es of America
	after death w or Iteme 23e	nu	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Orig n, Mexican,	jin? (Specify Y , Puerto Rican,	es or No- etc.)		American Indian, Vhite, etc.
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 📆 ¥idowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates:		1 □ Yes 2 🖫 👣 io	Specify:			SpecifWh:	ite
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ğ	e filed within al Hygiene. i other then '	Bec	17. Father's Name (First, Middle, Las	1)			18. Mother	r's Name (First	, Middle, Maide	n Sumame)	
<u>a</u>	Aental Aental rked c	To B	Joseph Nicko	les			E	Bessie	Shipley		
ary	should and Me s mark	4	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street a	and Number	r or Rural Rout	e Number, City	or Town, Stat	e, Zip Code)
Σ	and 2 alth a 27 I		William J. Green			Elmo Driv	ve, Ra	andalls	town, M	aryland	d 21133
ore	of Hea of Hea f Item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 {		<ul> <li>b. Place of Dispo cemetery, crer</li> </ul>	sition (Name of natory or other plac	<b>(9</b> )	Date	20c. l	ocation - City	or Town, State
<u>Ĕ</u>	Peges ment of I ant: If Its ury or o		4 ☐ Donation 5 ☐ Other (Special		mily R.	Catholic	Cem	01/31/	08 Ra:	ndalls:	town, MD, 2113
Baltimore,	permit. Peges 1 and 2 should Department of Health and Mer Important: If Item 27 Is marke any Injury or other treumatic ones.		21. Signature of Funeral Service Lice	250	22	2. Name and Address	ss of Facility	Coring	Bvers F	uneral	Directors, Inc
_	40539			Elennon		7/40_Trrn61	CLY KC	oau, ka	ngalist	own , Mai	ryland Z1133
			23a. Part1. Enter the disease, or conshock, or heart failure. List only		leath. Do not ent	er the mode of dying	g, such as c	cardiac or resp	iratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Gan	gren	e (e	Fr	100	P		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):	1 1	) \	<i>J</i> ,	00		seaso
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	D \ # #	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence or,	·					
	and and III-trar	xan	that initiated events resulting in death) Last	c Due to (or as a con	sequence of):						
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m.	death certifica e ettending ph od for use as t	Physician/Med	in the past 12 months?	1 Live birth 2 F		]Ectopic pregnancy ] Other (specify)				Month	Day Year
P.O.	by th	hys	9 Unknown	9∐ Unknown							
S,	as tha	by P	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause give	en in Part I.	C - A- 2	3e. Did tobacco		e to the cause of death?
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Records,	law r es be 2 sh	Completed						2.	4a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
<u>~</u>	The ete h page	5						11	performed? □ Yes 2 N	death	h? Yes 2□ No
<u>=</u>	ctor,	Be (	25. Was case referred to medical examiner?				26. Place	of Death (Che	ck only one)		
×	hysk his ca	ဥ	1 □ Yes 2 No	1	2 ER/Outpatien		4 L Nur		Pesidence		Specify)
ב	Ing P	Ö	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea.	r) 28b. Time of Injury	Worl			escribe how inju	ury occurred	
S	tend leath tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not I		100000000000000000000000000000000000000		Yes 2□N		antion /Ctract o	and Alumbar a	r Rural Route Number,
Division of Vital	or All	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	ecify)	eet, ractory, ornice			ity or Town, Sta		Autal Adule Number,
_	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate hes been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use		29a. Certifier	hysician: To the best of my	knowledge death	occurred at the tim	ne, date and	i place, and du	ie to the cause/	s) and manner	r as stated.
	24 hos Fun etely	edical	(Check only 2 Medical Exa	miner: On the basis of exam and manner stated.	nination and/or in	vestigation, in my or	pinion, death	h occurred at t	he time, date ar	nd place, and	due to the cause(s)
	nithin Fo th	Me	29b. Signature and title of certifier	~		29c. License	number		29d. D	ate signed (M	onth, Day, Year)
	> 0		Have	aya		Das	5112		01	28/8	3008
	1/		30. Name and address of person who	completed cause of death (	Item 23a) (Type,	Print) A		2 (	1 - 1		wings Hills
	5		Tahoora Kau	201	rossrc	ads 1	MIN	e 50	ulel	01 0	MD121117
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	AP					
	Registr	ar	JAN 2 9 201	18 Jan 1	F PAGE	Se de la company					

			For State Registrar	State of	Maryland / [	Department Certificate				giene 0	08	020	60
i	Physicia	an	1. Decedent's Name (First, Middle						2. Date of De Month Jan.	Day	Year 2008	3. Time of Do	
	/Medic Examin		Edgar Mills Go  4a. Facility Name (If not institution)		ber)	4b. City,	Town, or Locati	on of Death		4c. County		12.50	-
	LXUIIII		Fort Washington				Washin	gton		Princ			
Г	Funeral		5. Social Security Number 577–60–6764	6. Sex 7	7. Age (In yrs. last bii 91	Yrs. If Under Months	1 Year If Uni Days Hou	der 24 Hrs. rs Min.	8. Date of Bir (Month, Da Fob 1	th 2, 1916	9. Birthp Cour	lace (State or F etry) y Land	-oreign
	Director		Usual Residence of Decedent	AA .					100. 1.	2, 1710			
	arylan ahow	_	10a. State 10b. County	0	10c. City, Tow						1	0d. Inside City 1 ☐ Yes 2	
	28a-f	Funeral Director	MD Prince	Georges	Fort W	ashington 101. Zip				10g. Citizen of	What Cour		AA
3	3a or		7109 Webster Li	1.		2074				U.S.A			
	ems 2	nera	11. Marital Status	Armed For	dent Ever in U.S. ces?	13. Was Deced	ent of Hispanic ify Cuban, Mex	Origin? (Specican, Puerto	ecify Yes or No Rican, etc.)		ce - Americ		
250	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. I the file file at 71 is marked other than "natural", or Items 23a or 28a-f ahow other traumatic avent, the Medical Examinar must be multiled at	þ	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 Teryes	2 □ No tes: 1941	1 □ Yes 2				Specil	y: Whit	ce	
5	72 hou	Completed	15. Decedent (Specify only highes	's Education		Decedent's Usua (Give kind of wor life. DO NOT us	l Occupation k done during t	most of work	ing	16b. Kind of B	usiness/ln	dustry	
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ע	1 and 2 Health tam 27		Marjorie Golder  20a. Method of Disposition	i (wire)		109 Webst of Disposition (Namery, crematory or o			Wasning Date	20c. Location			
Dallillor	Pages nent of int: if it ury or o		1  Burial 2  Cremation 4  Donation 5  Other (Si		state	and Veter		Feb.	5,2008	Chelten	ham,	MD	:
	permit. Pages 1 an Depertment of Heal Important: if Itam 2 any injury or other once.		21. Signature of Fuveral Service		0 (	22. Name an	d Address of Fa	acility Lee	Funera	al Home,	Inc.		
<u> </u>	89 E 2 8		23a. Part 1. Enter the disease, of	complications that ca	Jon 1004	3 6633 O					nton,	MD 20	
	Physician /Medical Examiner	Iner	shock, or hear failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	b	MOSCUS or as a consequence or as a consequence		CAND	IOVAS	EUZAA	_ DUE	AS	Onset and De	iath C
,00,00	w requires that the death certificate be executed been signed by the ettending physicien and should be detached for use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to {c	or as a consequence	of):							
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cords, r	en signed build be det	ed by P	Part II. Other significant condition	ons contributing to de	ath but not resulting	in the underlying c	ause given in P	Part I. OKA A		tobacco use cor Yes 2 No		he cause of dea pably 4 ⊟Un	1
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DIVISION	To the Hospital or Attending Physician: within 24 hours elter death To the Funeral Director; After this certific completely filled in by the funeral director,	Certification:	2 Accident INVESTIG	not be 28e. Place	of Injury - At home, f ng, etc. (Specify)	arm, street, factory				(Street and Num own, State)	ber or Rur	al Route Numbe	e <i>r</i> ,
	a Hospita 24 hours a Funeral letely filler	Medical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the Examiner: On the ba and mann	isis of examination a	ge, death occurred nd/or investigation	at the time, dat in my opinion,	te and place, death occur	and due to the red at the time	cause(s) and m , date and place	anner as s , and due t	stated. the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifie	r		290	. License numl	ber		29d. Date sign	ed (Month,	Day, Year)	
	/		1115			1/	1-18	> 45	7	JANU	424	45,6	CO3
	/												
	h		30. Name and address of person	who completed cause	e of death (Item 23a)	(Type, Print)	1.(0)9	- CEN	UTGA	WAO	OF.	4d.2	200

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month January 25, Henry E. Gruppe 2008 3:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 10925 Deborah Drive Potomac Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 23, 1929 9. Birthplace (State or Foreign **Funeral** Months New York 1 X M 2 □ F 5**7**9-32-8094 78 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 1 ☐ Yes 2 X No Directo Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 10925 Deborah Drive 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status within 72 hours after 1 X Yes 2 No
If Yes, Give
Year or Dates: Korea 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify <u>چ</u> Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) U.S. Agency for Elementary/Secondary (0-12) College (1-4or 5+) 5+ Project Manager International Development Pages 1 and 2 should be filed and tof Health and Mental Hyginant; If Item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Gruppe Camille Plasschaert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lee Nelson/Wife 10925 Deborah Drive, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. Jan. 26, 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 'Department of HIMDortant; If ite any injury or of 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bethesda, Maryland 4 Donation 5 Dother (Specify) 2008 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy
Rosert A. Pumphrey Funeral Home/Chase, Inc.
7557 Wisconsin Ave., Bethesda, MD 20814-3501 21. Signature of Funeral Service Licenses M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 MONTHS Immediate Cause (Final Pancreatic Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed Exami burial-trar that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 24a. Was an autopsy 1 Yes 2X No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 \$\ Residence 6 Other (Specify) Hospital: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation Injury 1 X Natural 124 hours after death.

The Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marrier stated. and may within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D33293 January 25, 2008 30. Name and address of person who combleted cause Frederick P. Smith, M.D. M.D. 5454 Wisconsin Ave.,#1300, Chevy Chase, Maryland 20815

DHMH 17 Rev 1/2001

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State Registra

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 24, 2008 10:00 P.M Florence W. Goldsmith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Manor Care Potomac Potomac If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖺 F 530-14-8664 1914 Pennsylvania 93 Director 20, Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No Directo Maryland | Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 11830 Enid Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or the any injury or other traumatic event, the Medical Examinar 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: à Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julia C. Bonin Anthony G. Wallace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister 11830 Enid Drive, Potomac, Maryland 20854 Dolores M. Sherno / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 30, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) Calvary Cemetery Drums, Pennsylvania 21. Signature of Funeral Service dicense Robert A. Pumphrey Funeral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Et ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, ot heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Havancor Demen /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed signed by the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ◯ No 24a, Was an autopsy performed? Yes 2 2 0 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No ၉ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1.⊠Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 0054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bhogariki 9801 Georgia Avance Such 1-17 32 Registrar's Signature Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Mai	ryland			nt of Header			Reg. No.	008	0206	53
			1. Decedent's Name (First, Middle, Last)							2. Date of D Month	eath Day	Year _	3. Time of Dea	ath :
	Physicia /Medic		PAUL JAMES	GUZZE	<b>)</b>					JAN.	23	2008	0420	М
	Examin		4a. Facility Name (If not institution, give s	treet and number)			,		cation of Dea	ith		ounty of Death		
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	Funeral		5. Social Security Number 6. Sex	M 2□F		ast birthday) Yrs.	Months		Hours Mir	n. (Month, D			lace (State or Fo.	reign
	Director	}	213-30-5156		74					07-13-	1933	Mary	Land	
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171	lled v		17. Father's Name (First, Middle, Last)	4		broker		18	3. Mother's Na	ame (First, Middl				
yland	ntal h	Be	Joseph Guzzo						Helen	(Unknown	)			
5	nouk d Me mark matic	ပို	19a. Informant's Name/Relationship (Ty)	pe. Print)		19b. Mailin	g Addres			Rural Route Num		Town, State, Zip	Code)	
2 2	id 2 s ith an 27 is treu		Kathleen Guzzo (W:							Havre de				
a .	Hee Hee tem		20a. Method of Disposition		20b. P	face of Disposemetery, cren	sition (Na	me of	1	Date	20c. Loca	tion - City or To	own, State	
e i	age ento nt: if ry or		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donetion 5 ☐ Other (Specify)	emoval from State		dens o			01-	26-2008	Balt	imore,	Maryland	i
altimo	permit. Pages 1 and 2 should be lied within 72 hours after death with the maryland Department of Heelih and Mental Hygiene. Important: If liem 27 is marked other than "netural;" or items 23e or 28e-f show eny injury or other treumatic event, the Madical Exeminer instal be notified at once.		21. Signature of Funeral Service License	99	1			nd Address		chimunek				
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	To the Hospitel or within 24 hours after To the Funerel Director Completely filled in E	Me	29b. Signature and title of certifier	•				9c. License r				signed (Month,		
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			30. Name and address of person who co	ompleted cause of de	ath (Iten	23a) (Type,	Print)			11	1 -			
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08-00487 Russell Goff Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ussell Goff	1	State - For State	of Maryland		rtment of tificate of		and	Menta	al Hygi		- N-	200	8	0206
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Deceden Armed Forces	?	S. 13. Was	Decedent s, specify	of Hispa Cuban, I	anic Origir Mexican, I	n? ( Specif Puerto Rica	y Yes or No an, etc.)	- 14	Race - Ame White, etc.	erican Indi	an, Black,
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MD and 2 shot thith and m 27 is aumatic		Sharon Beattie/	cousin		1209	Неар	Roa	d Sti	reet,	MD 2	21154			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		20a. Method of Disposition			Place of Disposit crematory or oth		of ceme	etery,	Di	ate	20c. Loc	cation - City	or Town, S	State
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Baltimore, permit. Pages 1 at Department of He Important: If ite	ŀ	21. Signature of Funeral Service Lic	ensee.		22. N	me and A	ddress	of Facility	ard	655 W	Ral	timore	Str	eet
E Pe W		/ Immall	Wade, Di		Ba1	timo	e. l	MD = 2	21201					
Physician		23a. Par I. Enter the disease, or confail are. List only one cause on	nplications that cause each line.	the death.	. Do not enter th	e mode of	dying, s	uch as ca	rdiac or re	spiratory arr	est, shock	, or heart		oximate Interval veen Onset and
/Medical xaminer		Immediate C= se (Final disease	<sub>a.</sub> Atherosclerotic			ase co	nplica	ted by E	Environr	mental Hy	potherr	nia		Death
		or condition resulting in death)	Due to (or as a cons	sequence of	f):									
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Division of Vital Records, P.O. Box 6876 Hospital or Attending Physician: The law requires that the death certificate 24 hours after death. Funcral Director: After this certificate has been signed by the attending phytely filled in by the funeral director, page 2 should be detached for use as the U.	Certification:	3 Suicide 6 Could n	ot be 28e. Place of	Injury - At h	ome, farm, stree	t, factory,	office bu	uilding, etc				Number or Baltimore,		ite Number, City
Divis	Ser	4 Homicide determi	(9,000.))		ler overpass									
the the	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Chack only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.  (Chack only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)												
To To com	Mec	29b Signature and title of certifier	and manner stated	J		29c	License	number			29d. Da	ate signed (	Month, Da	y, Year)
		( Celerles	111				O.C.N	Л.E.			Janua	ary 18, 20	800	
		30. Name and address of person wh	no completed cause of	death (Item	n 23a)									
4			istant Medical Ex		111 Penn	Street,	Baltim	nore, M	D 21201	l				
	ate	31. Date filed (Month, Day, Year)	2008 32 Registr	ar's Signat	ure de	de)								
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		1- For State Certificate of Death Reg. No.	Time of Direk
Physicia Medical Examir	ier	1. Decedent's Name (First, Middle, Last)  A Libert Washing the Gode TF  4a. Facility Name (if not institution, give street and pumber)  4b. City, Town, or Location of Death  4c. County of Death  4c. County of Death	3. Time of Death 1729 hrs
}	Н	8 Aspinwood Way Apt. G  Rosedale  Baltimore Coun	ty
Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birth 22D-19-6057 12M 22F 28 yrs. Months Days Hours Min. 05/5/1979 Foreign Countries of the countr	113
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rs after nral", o	ģ.	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/In-	dustry
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s, MD 21 and 2 should lealth and Me ten 27 is ma traumatic ev	٤	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  Albert Gode TIL/Father 1317 5: Dahlia CT, Belaic, M	ZID CODE) WD 21015
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Physician /Medical	/	a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death)  a. Seizure disorder  Due to (or as a consequence of):	20011
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Division  To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu		298 Centrer	
To the To the Comp	Medical	and manner stated.  29b. Signature and title of certifier  29d. Date signed (Moi	
		(a(UUCCU)) O.C.M.E. January 23, 2008	3
, p/		30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
	ate	31. Date filed (Month, Day, Year) 2008 32. egistrar's Signature	
Regis	rar	JAN 2 9 2008	

State of Maryland / Department of Health and Mental Hygiene 1 - State Amend #1, perMD, #19a, perFh, 0875, 1/29/03/Tate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** MA OV:P OASTERD Marian G. Halstead Januari 2008/Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner GIEN TALEVII.

If Under 1 Year | If Under 24 Hrs.

Days | Hours | Min. ANNE ARUNDEL BAHIMORE Washington Medical Center Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 218-26-6840 Usual Residence of Decedent 6 Jaryland Director 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notifled at 1 ☐ Yes 2 No Millersville MD **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number ō 21108 recht or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. White Specify: Be Completed by 3 Widowed 4 □ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than College (1-4or 5+) 11 Atlantic other 18. Mother's Name (First, Middle, Maiden Surname, Maryland f Health and Menta Alstea 19b. Mailing Address (Street and Number or Rural Route Numbe - Cummings Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) Department of 3 ☐Removal from State any injury or Important: If 21. Signature of Funeral Service Licenses OMDASSION 9-1615-Stricker St. Borricker 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONCESTIVE HEART FAILURE 2AABY 4 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PAAHAAOO 19 T. 24 24921d Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2⊠No detached 1 the 9□Unknown 9 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 CORD 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ¥Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3∐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) au congress say amacoul D0065714 244014 d 2 5008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CIANERECO CUILLERMO DOSE 301 HOSPITAL DRIVE, GLEH BURLIE, MD 20161

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Month Physician teARd HenRY ONALd /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMURE VA MediCAL moR NIA entel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year July 29, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funerai Days 1**∑**M 2□F 408-78-1341 60 Yrs. 1947 Tennessee Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 Yes 2 No Directo Maryland Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be 7303 Forest Avenue 21076 USA Pages 1 and 2 should be filed within 72 hours after death vnent of Health and Mental Hygiene.
unt: If item 27 is marked other than "natural", or items 23s Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 N Yes 2 No 1969
If Yes, Give
Year or Dates: 1970 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Completed by Specify: White 3 ☐ Widowed 4 🏋 Divorced 16a. Decedent's Usual Occupation Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer 12 Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Perry ပ Clinton Heard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9110 M Tumbleweed Run Laurel, Melisa Heard, Daughter Maryland 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/26/08 Baltimore, Maryland 21. Signature of Funeral Serviced icensee
Thomas Gregor <sup>22</sup> Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Meumoni A **Physician** DAY /Medical Due to (or as a consequence of): Examiner CANCER -UN9 Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Phy SemA Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical OBACCO YEARS IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No autopsy performed? Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c, License number

State

Registrar

JOHN

31. Date filed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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GREENE ST K

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** The 1 ma В. Hart 2008 1:25 a M January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Stella Maris Baltimore Timonium 8. Date of Birth (Month, Day, Yea Sept 20, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** Days Year. Months Hours 1 □ M 2 □ X F 83 218-14-5397 1924 Mary land Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at Baltimore Lutherville 1 ☐ Yes 2 XNo Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21093 32 Croftley Road USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify. White 3 X Widowed 4 □ Divorced Year or Dates: "natural", other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farm Equipment Secretary land 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f is marked Frank J. Buettner Josephine Pfeifer and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Item 27 i Louise Retzer/ Niece 107 South Evergreen Ave. Arlington Hgts., Ill. 60005 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Department of H Important: If Ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 1-31-08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. <sup>22</sup> Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral ervice Linensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HEART Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, county to in resolutions. Enter Underlying Cause (Disease or injury Due to for as a nonsequence of: Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar and Due to (or as a consequence of) or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 XNo the 9□Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an has autopsy performed? Yes 2 No Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hus Public 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? Division or Attending (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0, TARIQ MAHMOOD, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 29 2008 Registrar

2008

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JANUARY

HART,

08-0	0560	
Lisa	Holley	

sa Holley		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar  Certificate of Death Reg. No. 2008 0206
Physici ledical Exami		1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year 0000 hrs
Jourga, Exami		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
Funeral		Johns Hopkins Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year  If Under 24Hrs.   8. Date of Birth (MM/DD/YYYYY)   9. Birthplace (State or Foreign
Director		146-74-9366 1 M 2XF 38 Yrs. Months Days Hours Min. 9-16-69 BALTINGREMO
any		Usual Residence of Decedent  10a. State 10b. County 110c. City, Town or Location 10d. Inside City Limits
* .	7	MA BALTIMORE 1 XYes 2 No
ith the Maryland 23a or 28a-f sho notified at once	irect	10e. Street and Number 10g. Citizen of What Country?
with the ns 23a o	<b>Funeral Director</b>	2723 Petham Ave.  212. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Eximiner must be notified at once	Fune	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.
ours after atural" comine	d by	3 Widowed 4 Divorced of Specify: 1 Yes 2 No specify: Specify: White.  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
1215-0036 Id be filed within 72 hours after tental Hygiene. narked other than "natural", event, the Medical Examiner	Completed by	Elementary/Secondary (0-12)  College (1-4 or 5+)
5-0036 iled within Hygiene. I other tha		17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
	To Be	Frederick 15. (occhiella JR. Nancy UNKNOWN  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru I, Route Number, City or Town, State, Zip Code)
O # B is E		Gina T. Cucchiella Cousin 36 Sulvan Park Ct. Perry Hall MD 21236
ore, MI ggs I and 2 s nt of Health a t: If item 27 other traum:		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, part of the place)  20c. Location - City or Town, State crematory or other place)
Baltimore permit, Pages I a Department of He Important: If it		4 Donation 5 Other Specify: Evans Funcial Chasel-BLAI 130 08 Forest Hill, MD  21. Signature of Funeral Service Licensee  22. Name and Address of Facility RD RD BACTIMORE, MD 21234
		23a. Part I. Enter the dij ease, or of polications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
Physician /Medical xaminer		failure. List only the cause in each line.  Immediate Cause (Final disease a. BLUNT FORCE INJURIES  Between Onset and Death
Kaiiiiiei		or condition resulting in death)  Due to (or as a consequence of):
	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
<u>≅</u> g √√	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
60, e be executed ysician and burial - transi	edical I	d
		IF FEMALE:  23c. If yes, outcome of pregnancy  23b. Was decedent pregnant in the  1 Live birth  2 Fetal death  3 Ectopic pregnancy  Month  Day  Year
Box 68760 e death certificate be the attending physical for use as the bu	Physician/N	past 12 months?  4 Pregnant at time of death 5 Other (Specify)
. 4 74		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ls, P.O quires that t en signed by	ted by	1 Yes 2 No 3 Probably 4 Unknown
of Vital Records, ig Physician: The law requir Wher this certificate has been sureral director, page 2 should	Completed	24a. Was an autopsy findings available autopsy prior to completion of cause of performed?
al Rein: The sertificat	Be Co	25. Was case referred to medical examiner?
n of Vit ding Physic After this (	ဥ	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA Outer 4 Nursing Home 5 Residence 6 Other:
	ation	27. Manner of Death  1 Natural 5 Pending Investigation Pending Inv
Division spital or Attendio ours after death. reral Director: /	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
E 8 5 E		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		O.C.M.E. January 21, 2008
Y   OCA	Ε	30. Name and add/s 5 of person who completed cause of death (Item 23a)  Mary G. Rapple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201
St	ate	31. Date filed (Month, Day Year) 2000 32 Registrar's Signature
Regist	trar	JAN 2 9 2008 January 18 18 18 18 18 18 18 18 18 18 18 18 18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician NHO ANUARY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** RANDALLSS CENTER D BALTIMORE MARTHWES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days **M** M 2□F Hours Director 218-07-9369 17 06 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21207 3208 Blue Hill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Coilege (1-4or 5+) Elementary/Secondary (0-12) Beth Steel Corp Crew Boss 2yrs <u>12th grade</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Rosa Lee Briggs 2 <u>Eleazer Hill</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 3208 Blue Hill Road, Baltimore, Md Sarah Hill-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2/2/08 Baltimore Co, Md Woodlawn 21. Signatur of Funeral Service License 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a ARTERIDSCLERDIL LARDIDVASLULAGE **Physician** /Medical Due to (or as a consequence of): **Examiner** Scale nizing little actions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attanding Physiclan: The law requires that the death certificate be executed iffer death. Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? res 2 No death? 1 ☐ Yes this certificate 2 No 1☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 R/Outpatient 3 DOA 1 | Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

5401

32. Raskar's Signature

FABER

Year)

31. Date filed (Month, Day,

OLO COURTROAD, RANDALLSTONN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death January 20,2008 a **Physician** 1:10AM M Hamer, Sr. Heinrich /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Clinton Future Care Pineview If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) June 30, 1928 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 ☐ F Germany 79 Director 132-34-8900 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Prince George's Clinton 10a. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20735 German 9106 Pineview Lane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. be filed within 72 hours after ontal Hygiene.
Indeed other than "natural", or iter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🌠 No White Specify: Specify: ò 3 XVidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Home Construction 12 Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental is marked Anna Dorathea Dorowsky Hamer Hermann 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra 10601 Land Tree Drive Upper Marlboro, Maryland 2077 (Son) Henry Hamer, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 31. Jan. 1XXBurial 2 □Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Clinton, Maryland 21. Signature f Fune at 3. ce Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735 23. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Saque tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of): physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 ☐ Other (specify) 4□Pregnant at time of death the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed een 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform eb d certificate ! i⊟ Yes uneral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 2 After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No the 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760 P.0. Division or Vital Records.

Baltimore, Maryland 21215-0036

requires that the death certificate be executed Physician: or Attending To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by

6 ☐ Could not be determined 4 Homicide

29a. Certifier

(Check only ona)

Medical

State Registrar

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

18545

28,2008

Name and address of person who completed cause of death (Item 23a) (Type, Print)

115875K 12070 Old Line Centre Waldorf, Maryland 20602 RAID-31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend it tem 10 and Department of Health and Mental Hygiene Reg. No. 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** LILLIAN HORSE TAN -6 2008 /Medical Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner altmore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/22/1926 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days 1 □ M XXF 214-20-9853 81 MARYLAND Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 XYes 2 No N/A BALTIMORE CITY Director MD 10e. Street and Number AND 10f. Zip Code 10g. Citizen of What Country? USA 21215 -AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married BLACK Maryland 21215-0036 1 □ Yes 2 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LIBRARIAN BALTIMORE CITY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fill Health and Mental H tem 27 is marked otl CLARENCE HORSEY CARRIE SMITH traumatic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4211 GROVELAND AVENUE, BALTIMORE, MD 21215 SAMADAH MUBDI-BEY / DAUGHTER Important: If Item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
KING MEM. PARK CEM. Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1XDBurial 2 ☐ Cremation 3 ☐ Removal from State 01/31/08 WINDSOR MILL, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Freeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVENUE, BALTIMORE, MD er the disease, or complications that caused the death. eart failure. List only one cause on each line. ot enter the mode of dying, such as cardiac or respiratory arrest, te Juse (Final Physician ONGESTIVE /Medical Due to (or as a consequence of): Examiner ORDNAR if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed HRONK burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician GASTRO INTESTINA Physician/Medical IF FEMALE: nse f yes, outcome pf pregnancy □ □Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for L in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy 1□ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) 2 No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3□ DOA Certification: To this Date of Injury (Month, Day Year) 27. Manner of Death 28a. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation Injury 1 □ Yes 2 □ No 2 ☐ Accident 24 hours after death Funeral Director: 8 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide tipicertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02073 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month D3:300 M 98 Soos Dianna Lynn Helsel 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11/16/1950 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Hours 1 ☐ M 2 🖾 F 212-58-6234 57 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Anne Arundel Crownsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2013 Martins Grant Ct. 21032 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 🖾 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Contract Worker Defense Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Lake Mary "Sue" Weir 19a. Informant's Name/Relationship (Type. Print) husband/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

**Physician** /Medical Examiner physician and s the burial-transit Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

"naturai", or items 23a or 28a-f show dica! Examiner must be notified at

Director

Funeral

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Be Completed

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MD

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Mr. Richard "Pet			rtins Grant C		ille, MD	21032
20a. Method of Disposition  1 ★Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp.	B □Removal from State	Place of Disposition cemetery, crematory	or other place)		Location - City or	,
21. Signature of Funeral Service L		ruens of r	aith Mem. 2/1	/2006   Ba	iltimore	(overlea),M
Mark.	areur Mois		e and Address of Facility S vices; 1 2nd			
23a. Part1. Em. II e disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	omplications that caused the deality one cause on each line.  a. Due to (or as a conse	sis	mode of dying, such as card	iac or respiratory arrest,		Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	Due to (or as a conse	equence of):	n Stroke			
resulting in death) Last	Due to (or as a conse	equence of):				
if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  Part il. Other significant condition	23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3 ☐ Ector	oic pregnancy r (spe <i>cify</i> )		23d. Date of de Month	livery Day Year
Part il. Other significant condition	-	sulting in the underlyi	ng cause given in Part I.			o the cause of death?
				24a. Was an autopsy performed 1∐ Yes 2 ☑	prior to death?	utopsy findings available completion of cause of
25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)		
1 Yes 2 X No	Hospital: 1 X Inpatient 2[	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	e 6 □Other (Spe	ecify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	njury occurred	y
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		home, farm, street, fa hify)	ctory, office	28f. Location (Street City or Town, St	and Number or R ate)	ural Route Number,
29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of my kr kaminer: On the basis of examinand manner stated.	nowledge, death occu nation and/or investiga	rred at the time, date and pla ation, in my opinion, death oc	ice, and due to the cause curred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
29b. Signature and title of certifier		)A -C	29c. License number	1 0	Date signed (Mont	
30. Name and address of person w	ekers Ar	ne Aru	2001 Medical	Parkway	<u></u>	
31. Date filed (Month, Day, Year)	32/Registrar's Sign	nature 🥒 🛕				
		ORIGIN	AI.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month
JANUARY 24, 2008 8:10P **Physician** MARGARET LEONA JORANKO /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** GILCHREST HOSPICE CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 □ F 216-18-6616 84 1-20-1924 MARYLAND Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No MD BALTIMORE ROSEDALE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or 7 must be n 1829 HANFORD ROAD 21237 U.S.A. Funeral filed within 72 hours after death 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. "natural", or iten 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the once. PACKER LEVER BROTHER 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BENJAMIN MOSETTI ANNA 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL JORANKO/HUSBAND 1829 HANFORD RD ROSEDALE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH | 1-28-08 BALTIMORE, MD of Financial Prince Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UULUAR CANCER tastnic Physician lean disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed physician and is the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed' certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

Certification:

Medical

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a Certifier

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

6701 N. Chales St. Balts Ml 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6

29d. Date signed (Month, Day, Year) TANUMY 25, 2008

State Registrar

BMC 31. Date filed (Month, Day, Year)

32. Redistrar's Signature

# Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural"; or items 23a or 28a-f show any Inliny or other traumstic event, the Medical Examiner must he notified at

Division or Vital Records, P.O. Box 68760,	
To the Hospital or Attending Physician: The law requires that the death certificate be executed	Pr / Ex
within 24 hours after death.	M Ka
To the Funeral Director: After this certificate has been signed by the attending physician and	ed m
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	lic in

		Please	Type or Prin						•	9	ole.	
	For State Registrar		State of Ma	aryland	-	artment of H rtificate of L		na Mei		ne . No. 🤈 🕦	0.8	0207
in al ₃	1. Decedent's Name		Marie		J	enkins		1	Date of Death Month		Year	3. Time of Death
		Side He	alth Care Sex 7. Ag 1 M 2 XF 7.8		a <i>st birthday)</i> Yrs.	4b. City, Town, or Balt:  If Under 1 Year  Months Days	imore	Hrs.   8	Date of Birth (Month, Day, Y	NA (ear)		ace (State or Foreiq ry)
	Usual Residence of 10a. State	Decedent 10b. County	-	10c. City,	Town or Lo	ocation					10	d. Inside City Limit
일 년	MD 10e. Street and Nu	NA mber		Bal	ltimo	10f. Zip Code			10g	. Citizen of W	/hat Count	1 X Yes 2 □ N ry?
by Funeral	1669 N.  11. Marital Status  1 □ Never Marr  3 ☑ Widowed	ied 2 Married	AVE  12. Was Decedent Armed Forces?  1 □ Yes 2 □ If Yes, Give A Year or Dates:			21213 Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2☐ No	ispanic Origin In, Mexican, F Specify:	n? (Specif Puerto Ric			- America K, White, e	tc.
Completed	Elementary/Seco		rade completed) College (1-4or 5	ŝ+)	(Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	during most o  )	f working		b. Kind of Bu	siness/Ind	ustry
Be	7th G:	(First, Middle, Las	NA st)		Pr	ivate Du	18. Mother's		First, Middle, Ma	T.Mar		<u>'illa</u>
Γij	William:  19a. Informant's N	ame/Relationship	(Type. Print)	rell	19b. Mailir	ng Address (Street a	and Number		Route Number, C		State, Zip (	,
1 1-		oosition Cremation 3 [ 5 Cother (Spec	□Removal from State	ce	ace of Dispo emetery, crei	osition (Name of matory or other place  Mem Par  2. Name and Address	Park 2/1/08 Arbutus,MD				vn, State	
er	23a. Part1. Enter shock, or hea Immediate Cause disease or condition resulting in death)  Sequentially list confiant, leading to incause. Enter Unde Cause, (Disease or Cause, (Disease,	rt failure. List only (Final n	mplications that caused your cause on each lit a.  Due to (or as Due to (or a) Due to (or as Due to (or a) Due to	ne. USA a consequi WS	ence of):	Deel		rth	Ave Ba	altimo	ore,	MD 2120 Approximate Interval Between Onset and Death
Physician/Medical Examiner	cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	Last	23c. If yes, outcome	Um pf pregnan	ncy	byjele.	-			23d. Date	e of deliver	у
hysicia	in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknown	months? ☐ No	1∐Live birth 4∐Pregnant at 9∐Unknown			□Ectopic pregnancy □Other (specify)		-			Day Year	
þ	Part II. Other sign!	ficant conditions	contributing to death b	ut not resul	ting in the u	nderlying cause give	en in Part I.	_	23e. Did tobac			e cause of death?
Completed								_	24a. Was an autopsy performe 1∐ Yes 2₽	d? p	rior to com eath?	sy findings availat pletion of cause o 2□ No
ation: To Be	25. Was case referexaminer?  1  Yes 2 2  27. Manner of Deat  1  Natural  2  Accident	No h 5 ☐ Pending investigatio		iry	R/Outpatier 28b. Time o Injury	f 28c. Injury Work	er: 4 Nursi	ing Home	Check only one)  5 ☐ Residence  I. Describe how			)
l Certification:									City or Town, State)			
Medical	29a. Certifier  (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Mo									and due to	the cause(s)	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHDAIJ A. ITAS HM MI) 821 N. Endam St. Finite Jo. F. 13AU									8 (03	3	
	SHOALLS	A. 1+1	78thm1 M	1) 8	2 ( ()	V. Enla	n S	J- 8	inte 30	J 134	ALTI1	nortemi)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Marylar		artment of rtificate of				711118	02076
9		Decedent's Name (First, Middle,	Last)			Douin		. Date of Death	ng. Nfor:	3. Time of Death
Physic		DOROTHY	MILDRED	JE.	CELIN			Month	Day Year	
/Med Exam		4a. Facility Name (If not institution,			4b. City, Town,		of Death	Jan.	28, 2008 4c. County of Deat	5:45A <sup>M</sup>
LAGIII	IIÇI	Genesis - Frank				ville	or Godan			
Funera	Г		. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	r If Under		. Date of Birth	Baltimo	holace (State or Foreign
Director		212-22-6935	<sup>1□M 2</sup> √ F 86	Yrs.	Months Days	Hours	Min.	Jan. 30	$\tilde{1}921$ Mai	cyland
, n		Usual Residence of Decedent	140.00							
h the Marylan r 28a-f show notified at	_	10a. State 10b. County		y. Town or Lo						10d. Inside City Limits
Ba-f	Director		ore City	Balt	imore Ci	ty				1 X Yes 2 No
with t	Dir	10e. Street and Number			10f. Zip Code			10	g. Citizen of What Co	untry?
s 23a	era	4404 Bayonne Av		- 1		1206			USA	
36 s after de , or item	Funeral	11. Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes XXIXNo	.S. 13.	Was Decedent of if Yes, specify Cub	Hispanic Ori oan, Mexican	gin? (Speci n, Puerto Ric	y Yes or No- can, etc.)	14. Race - Ame Black, White	
036 urs aft	by	3 ☐ Widowed 4√ Divorced	If Yes, Give Year or Dates:		on <mark>√∏k</mark> seY⊡t	Specify:			Specify: W	nite
5-0036 72 hours after death with the Maryland natural', or items 23a or 28a-f show alcal Examinan must be notified at	Completed	15. Decedent's	Education	16a. Dece	dent's Usual Occu	pation		1	6b. Kind of Business/	Industry
within 73 ene.	pie	(Specify only highest of Elementary/Secondary (0-12)	Çollege (1-4or 5+)	(Give	kind of work done DO NOT use retire	i during most ed)	t of working			
21 arthur arthur	Con	7 yrs.	N/A	S	ales Cle	rk			People's [	Orug Co.
be filed within that Hygiene.	Be (	17. Father's Name (First, Middle, La	· ·			18. Mothe	r's Name (F	irst, Middle, M	laiden Surname)	
Via Duld I	2	Windsor Belt Pe	ltzer			Dor	othy	Elizabe	th Scheib]	Lein
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours aft to Health and Mental Hygiene. If itam 27 is marked othar than "natural", or or other traumatic avant, the Medical Exertion or other traumatic avant.		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Stree	t and Numbe	or or Rural F	oute Number,	City or Town, State, Z	ip Code)
		Nettie Walter (	Cousin)			e Aven			, Md. 2120	06
Baltimore, permit. Pages 1 ar Department of Heamportant: If item in y injury or othance.		20a. Method of Disposition  XX Burial 2 ☐ Cremation 3	1 0	lace of Dispo emetery, crea	sition (Name of natory or other pla	ice)	Date	2	Oc. Location - City or	Town, State
timent ment tant:		'4 □ Donation 5 □ Other (Spec		anite	Pres. Cer	metery	2-1-	2008 B	Baltimore,	Md.
Baltimory permit. Pages Department of P Important: If its any injury or of		21. Signature of Funeral Service Lic	ensee	22	Name and Addre	ess of Facility	y 1 Hom	Δ		
m dosad	12		sakn		<u>/401 Bela</u>	air Rd	. Bal	timore,	Md. 21236	6
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the death ly one cause on each line.	n. Do not ent	er the mode of dyi	ng, such as	cardiac or r	espiratory arres	st,	Approximate Interval Between
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/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):				· ·		
Examiner	<u>.</u>	Sequentially list conditions,	o. CAD, DI	ABE.	TES	, 4	TN			
sit 9d	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):						
20, and and rest.	хап	that initiated events resulting in death) Last	c	ionoo of):						
I Records, P.O. Box 68760, L. The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	a E		Doe to (or as a consequ	delice oi).						
phys	dical		d							
Box 6	Physician/Me	IF FEMALE:	23c. If yes, out <i>co</i> me of pregna	ncv						
Box eath cert attendin	ian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2☐Fetal	death 3	Ectopic pregnanc	у			23d. Date of deli-	very Day Year
P.O. B. that the death ed by the atterdet for	iysid	1 ☐ Yes → No 9 ☐ Unknown	9 Unknown	saui 5	Other (specify) _					
Is, P.C		Part II. Other significant conditions	contributing to death but not resu	ulting in the ur	iderlying cause giv	ven in Part I.		23e. Did toba	acco use contribute to	the cause of death?
Records, the law requires to has been signed age 2 should be considered.	d by	COPD, C	45		, , , , , , , , , , , , , , , , , , , ,			1 ☐ Yes	11	
Cord	ete	1				-		24. 116		
Vital Rec sician: The law certilicate has b irector, page 2 s	Completed					-		24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
n: Th		05.18							No 1 ☐ Yes	2 No
of Vital Physician: T this certificate ral director, pa	o Be	25. Was case referred to medical examiner?	Hospital:		Ott	or L		heck only one		
Of Phys		27. Manner of Death		ER/Outpatien 28b. Time of	3 DUA	4 Uniur			ce 6 Other (Special injury occurred	ify)
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Division  I or Attandii after death. Diractor: A	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Injury - At ho	me, farm, stre				Location (Stre	et and Number or Rur	ral Route Number
Div A after I Dirac	Certification;	4  Homicide	building, etc. (Specify	)	ot, lastory, onlog		251.	City or Town,		arriouse reamber,
spite nours nara		29a. Certifier Certifying F	hysician: To the best of my know	vledge, death	occurred at the tir	me. date and	place, and	due to the cau	se(s) and manner as	stated
a Ho 124 h a Fu letely	Medical	(Check only 2 Medical Exa	miner: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my o	pinion, death	n occurred a	at the time, date	e and place, and due	to the cause(s)
Division of Vital Re To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Me	29b. Signature and title of certifier			29c. Licens	e number		290	1. Date signed (Month,	, Day, Year)
		Min Par	shall		D4	000	8		112811	78
.0		30. Name and address of person who	completed cause of death (Item	23a) (Type I	Print)		V		( > - V ) (	V
10		JIM PARSHAL	L 9195 FF	2ANK	LIN S	QUAR	& D	P., BA.	LTIMORE	MD.
And Property lies			2009 32. Aegistrar's Signat	160-	- all			10		/
Sta	ite	31. Date filed (Month, Day, Year)	2000	AL SIL	MARIE I					

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			1 - For State Registrar	State of	Maryland / Dep	partment of F Prtificate of			giene 20	08	02077
-	Physic	ian	1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea	th		3. Time of Death
	/Med		Jeffry A					Month Jan.	27, 200	Year 8	5:18 A M
	Exami	ner	4a. Facility Name (If not institution, g	ive street and numb	per)	4b. City, Town, c	or Location of Dea	ith	4c. County		
			124 Alview Terra 5. Social Security Number 6.		Ano /In uso look hinth do		Burnie   If Under 24 Hr		Anne	Arur	ndel
	Funeral Director		214-94-5261	18∑M 2□F	. Age (In yrs. last birthda	Months Days	Hours Mir	. (Month, Day	, Year)		lace (State or Foreign try)
	-		Usual Residence of Decedent		44			2-20-19	63	Mary1	Land
	nylan how	_	10a. State 10b. County		10c. City, Town or	Location				10	0d. Inside City Limits
	the Marylar 28a-f show	cto	MD Anne	Arundel		Gle:	n Burnie				1 ☐ Yes 21 No
	vith th	Director	10e. Street and Number			10f. Zip Code			0g. Citizen of W	/hat Count	iry?
	s 23a	era	124 Alview Terra			210			United		
	ter de item	Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married	12. Was Decede	ent Ever in U.S. 13	. Was Decedent of H If Yes, specify Cub	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		e - America k, White, e	
980	be filed within 72 hours after death with the Maryland stal Hygiene.  Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	3 Widowed 4 Divorced	1 Yes 2 If Yes, Give Year or Date	es: 1984–88	1 ☐ Yes 2 🛣 No	Specify:		Specify:	7.71.	• •
Õ	72 hor	ted	15. Decedent's I	ducation	16a, Dec	edent's Usual Occup	ation	- 1	16b. Kind of Bus		uite
21	thin 7 an "r Med	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4	or 5+) (Giv	e kind of work done DO NOT use retired	during most of wo d)	orking			,
2	filed wi Hygier ther th	S	12		Sen	ior Netwo	k Engin	eer	Gove	rnmen	nt
and	be fil ntal H od otl	Be	17. Father's Name (First, Middle, Las	t)			18. Mother's Na	me (First, Middle, I	Maiden Surname	e)	
Ĕ	hould d Mer narke	ဥ	Alfred S.				Ire	ene E.	<u>Eichelbe</u>	erger	
Maryland 21215-0036	d2s than t7 is r traur		19a. Informant's Name/Relationship			ling Address (Street					*
	ages 1 and 2 should be fil nt of Heatth and Mental H i: If item 27 is marked oth r or other traumatic even	-	Terri K. James / 20a. Method of Disposition	Wife	120b. Place of Disp	1view Ter	1	n Burnie	Maryla  20c. Location - 0	and 2	1060
9	Pages ent of nt: If i		1 ☐ Burial 2 🖾 Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec	Removal from Sta	ate cemetery, cr	ematory or other plac	í i .	10000		•	•
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice			el Cremat  22. Name and Addres		9/2008 (	Odenton,	. Mar	yland
m	Depa Impo any Ir		( Sympo )	Ollu	celles 1	Oonaldson [411 Annap	Funeral	Home & C	remator	y, P.	A:112
6			23a 1. Inter the disease, or conshock, or heart failure. List only	one cause on each	se ne death. Do not er	nter the mode of dyin	g, such as cardia	c or respiratory arre	est,		Approximate
-	Physician		Immediate Cause (Final disease or condition		astatic Kidi					(	Interval Between Onset and Death
d	/Medical Examiner		resulting in death)		as a consequence of):	ic, dancer					2 1/2 yrs.
Н	Lxammer		Sequentially list conditions,	b							
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Liner underlying Cause (Disease or injury that initiated events	Due to (or	as a consequence of):						
Ć,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	c Due to (or	as a consequence of):						
68760,	tificate be executed ig physician and as the burial-transit	edical		⊾d.							
_	rtifica ng ph as th		15.551111.5								
Box	eath cer attendin for use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor		⊒Ectopic pregnancy			23d. Date	of delivery	y
	res that the death cer igned by the attendir be detached for use	Physician/IV	in the past 12 months? 1 ☐ Yes 2 ☐ No		t at time of death 5	Other (specify)			Mont	th D	Day Year
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Records,	requires that the death cer een signed by the attendin nould be detached for use	Q	Tate in Outer Significant Conditions	contributing to death	rout not resulting in the t	inderlying cause give	n in Part I.				cause of death?
Ö		etec						1 Te	S 21 140 3	Probat	bly 4 Unknown
Re	r <b>sician</b> : The law r s certificate has be lirector, page 2 sh	Completed						24a. Was an autopsy	/ pri	ior to comp	sy findings available pletion of cause of
Vital	ifficate or, pa		25. Was case referred to medical						<b>⊠</b> No 1 [	eath? Yes 2	X No
>	Physician: this certificatal director,	To Be	examiner?	Hospital:	atient 2 ☐ ER/Outpatie	nt 3 DOA Othe		th (Check only one			
Or	g Physter this seral di		27. Manner of Death	28a. Date of Ir	njury 28b. Time o		4 □ Nursing H	ome 5 Resider			
Ö	Attending F death. ctor: After y the funer	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	1	Day Year) Injury		? ′es 2 ☐ No		,,		
Division	or Atto	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of	njury - At home, farm, stretc. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number	or Rural F	Route Number,
	Hospital or Attending 14 hours after death. Funeral Director: After tely filled in by the funer	S		No.					,		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 ☐ Certifying Pt (Check only one) 2 ☐ Medical Exar	niner: On the basis	st of my knowledge, deat of examination and/or in	h occurred at the tim vestigation, in my op	e, date and place pinion, death occu	e, and due to the ca	use(s) and mani	ner as stat	led. he cause(s)
	To the within 2 To the complete	Mec	29b. Signature and title of pertifier	and manner	sialed.	29c. License					
	- S - O		11000	1/ 1/1	4		310	-1 7	d. Date signed (	wonth, Da	ly, rear)
,	hill	-	80 Name and address of person who	completed cause of	death (Item 23a) (Type	Print)	213	>	anua	1.2	2 1008
1	111	(	Ju 55e112, De	Luca.	205	Hospila	l Dave	Glens	NIN' = 1	20.7.	10(0)
	Sta	_	31. Date filed (Month, Day, Year)	32. Regis	strar's Signature	N. J.		)		7 -	1-0
	Registra	ır	JAN 2 9 200	0	J 18 12 100	- Charles					

DHMH 17 Rev 1/2001

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 23,2008 Yea **Physician** Jacquelyn M. Johnson January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 1 □ M 2 13 F 87 Months Days Hours Min. Director 577-20-2732 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Directo Montgomery Village Maryland Montgomery 10e. Street and Number 10f. Zip Code 20886 9713 Inaugural Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 17. Father's Name (First, Middle, Last) Be Douglas C. McGraw Josephine Wick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen J. Johnson/Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition January 28, Parklawn Memorial Parklawn Memorial Park 1 → Burial 2 □ Cremation 3 □ Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License M01498 Logn. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE **Physician** /Medical Due to (or as a consequence of): Examiner MULTILOBAR PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: ate has been signed by the attendin page 2 should be detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ INTERSTITIAL LUNG DISEASE SCCONDARY TO AMIDDAMENTE Be Completed CONGESTIVE HEART FAILURE 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day Year) 28b. Time of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

10

State Registrar

Medical

9901 MEDICAL MADHAVI MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUBBLY

02078 9:40 PM

4c. County of Death

Montgomery

8. Date of Birth (Month, Day, Year)
November 22,1920 Washington, D.C.

10d. Inside City Limits 1 X Yes 2 No

10g. Citizen of What Country?

United States

14. Race - American Indian,

Specify: White

16b. Kind of Business/Industry

18. Mother's Name (First, Middle, Maiden Surname)

13724 Creola Court, Germantown, Maryland 20874

20c. Location - City or Town, State
Rockville, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850

Approximate Interval Between Onset and Death

23e. Did tobacco use contribute to the cause of death?

Month

Year

Day

1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

CENTER

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DU062562 Machon Hobble JANNANY 24

PRIVE ROCKUILLE MD

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.ZUU8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 6 Month 2 008 Hope Mabe1 Johns anuar 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 🕅 F 236-24-4809 89 May 19, 1918 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Crain Hwy. 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Evans Addie Moses 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Roland Smith/Trustee 400 Crain Hwy. SW Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Jan 30, 2008 Glen Haven Mem. Park Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services 1 2nd Avenue SW Glen Burnie MD 21061 AL0135 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset/and Death Immediate Cause (Final disease or condition resulting in death) neumonia days Due to (or as a consequence of): Lementia YLAVS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: f yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of

Physician /Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

show

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23a must

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Department of Health and Mental Hygic Important: If item 27 is marked other I any Injury or other traumatic event, th once.

1 and 2 should be

Pages 1 ment of F

Maryland 21215-0036

Baltimore,

the Medical Examiner

r 28a-f show notified at

Director

Funeral

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Completed

The law requires that the death certificate be executed

Examiner

Physician/Medical

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sician and burial-trans for detached page 2

completely filled in by the funeral director, s after death. n 24 hours a

Division or Vital Records, P.O. Box 68760,

-	

	performed 1 Yes 2 ₹	No	death? 1 □ Yes	2 No
th (C	heck only one)			
ome	5 Residence	9 6 □	Other (Speci	ify)

pel					1 ☐ Yes 2 ☐	] No 3 ☐ Probably 4 ☑ Unkno
Complet					24a. Was an autopsy performed 1 Yes 2 No	24b. Were autopsy findings availar prior to completion of cause death? 1 □ Yes 2 ☑ No
Be	25. Was case referred to medical examiner?			26. Place of Deat	h (Check only one)	
To	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DO/	Other: 4 Nursing Ho	ome 5 Residence 6	□Other (Specify)
cation:	27. Man r of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	3c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
Certific	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, street, factory,	office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
Medical	29a. Certifier (Check only one)  1	hysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, death occurred a tion and/or investigation,	t the time, date and place, in my opinion, death occur	and due to the cause(s) red at the time, date and	and manner as stated. place, and due to the cause(s)
ž	29h Signature and title of certifier		290	License number	20d Date	signed (Month Day Vens)

(Check only one)	2☐ Med

dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier Wul II

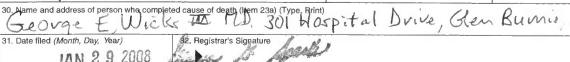
29d. Date signed (Month, Day, Year)

To the within 2

or Attending

State Registrar

31. Date filed (Month, Day, Year)



# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 02080

JI I a I	nes Jackson		1- For State Criticate of Death	Reg. N		0 0200
	Physici	an/	1. Decedents Halle ( 113t, Wildon, 223t)	Date of Death     Month Da	v Year	3. Time of Death 1023 hrs
Med	dical Exami		Carlos Jackson, Sr. Carlos Albert Jackson  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	January 20, 2	2008 4c. County of Death	
4			Johns Hopkins Hospital Baltimore			
	Funeral Director		5. Social Security Number 214-86-5753 6. Sex 1. X M 2. F 41 Yrs. Months Days Hours Min.	8. Date of Birth(N	1966 9. Bird 1966 Co	
	япу	F	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
N	*	7	MD Baltimore			1 XXYes 2 No
3.0	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland pepartient of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must he notified at ouce.	Director	10e. Street and Number 1205 Oakhurst Place 21216		Citizen of What Cour USA	
	er death with , or items 2	Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XX Divorced II Yes, Give Year  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XX No 1 Yes 2 XX No 1 Yes 2 XX No specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer White, etc. African An Specify:	ican Indian, Black, nerican
	ours aftu atural" camine	d by	3 Widowed 4 XX Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of working most of working life. DO NOT use retired.		b. Kind of Business/	Industry
	36 in 72 hc han "na lical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12 construction work		cons	struction
	21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	S	17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle, Maio		occurrent .
	121; 3 be fill ental F arked	a		Deborah Ja		7:- Code)
	MD 2.  nd 2 should alth and M m 27 is manarite e	잍	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or F  1205 Oakhurst Place; Balt			
	e, M 1 and 2 Health item 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		0c. Location - City or	
	MOF Pages nent of nent of ur othe		1   AADUMAI 2   Clemation 3   Removalition State		altimore, Ma	
	Baltimore, permit. Pages I ar Department of Her Important: If ite		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  638 North Gilmor Street	-	neral Home,	
	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o			Approximate Interval Between Onset and
10-	/Medical xaminer	ш	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			Death
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	ransit	Exa	events resulting in death) Last Due to (or as a consequence or):  d.			
	), be exec iician ai urial - t	Medical	X UNPENDED #1.perME.g876, 2/11/08 TT #1,23a,27,perME.g876, 2/4/08 TT			
	Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	ancy	23d. Date of deliver Month	ry Day Year
	D. Be tithe de by the ached f	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
	, P.C res tha signed be deta	d by		1 Yes		obably 4 Vunknown
	ords w requires been as been	Completed		24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
	Rec The la icate h	E		1 <b>✓</b> Yes 2		es 2 No
7	ital iician: s certif rector,	Be	25. Was case referred to medical examiner?  Hospital: Inpatient 2 FR/Outpatient 3 DOA Other Nursing		esidence 6 Othe	er:
7	Sion of Vital Attending Physician: death. ector: After this certif	1: To	1 V Yes 2 No 28a Date of Injury 28b Time of Injury 28c Injury at Work?	28d. Describe how		
#	sion trendir death. ctor: A	atio	1 X Natural 5 Pending 1 Yes 2 No			
	Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 Could not be determined (Specify)	28f. Location (Stre or Town, Stat		tural Route Number, City
	To the Hospita within 24 hours To the Funcral completely fille	Medical Ce		d due to the cause(s at the time, date an	s) and manner as sta d place, and due to t	ated. the cause(s)
	- 70 Kiti 10	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	
1			O.C.M.E.		January 21, 200	J8 
			30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 2	1201		
	Part of the Control o	tate	31. Date filed (Month, Day, Year)			
J. A.	Regis	માસ	JAN & V LOUD			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav 0250AM Year **Physician** Month Michael Kuruc 2008 )Ansaru 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT AGNES BALTIMORE HEALTHCATE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. 11-14-1926) 7. Age (In yrs. last birthday) 81 Yrs. 9. Birthplace (State or Foreign Country) Czechoslovakia 5. Social Security Number 173–20–8572 6. Sex 1 M 2 ☐ F **Funeral** Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Baltimore Lansdowne 1 □Yes 2X No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Third Avenue 21227 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

15 Yes 2 10 10 16 Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 .46 06-48 1 ☐ Yes 2 💢 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Social Security Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event; the Monge. once. Administration Beneficiary Authorization 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Kuruc 2 Anna Litvak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Imelda Kuruc/Wife 212 Third Avenue Lansdowne MD 21227 20b. Place of Disposition (Name of temetery, crematory or other place)
West Arundel
Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 1-25-2008 Odenton, Maryland 4 □ Donation 5 □ Other (Specify) lating Funeral Service Lice Ambrose Fuenral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence s): **Physician** 1 minute /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, physician a Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig , page 2 should b disease 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed certificate 20 Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 23,2008 BC9914795 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Meghan Cherkley Baltimore missyland 900 South Caton Avenue 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar IAN 29

DHMH 17 Rev 1/2001

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			Registrar				ertifica	te of L	Jeath	1	2. Date of		J. No.	JUB	3. Time	of Death
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1	/Medio		4a. Facility Name (If not institution		umber)		4b. City	, Town, or	Location	of Death				y of Death		
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energy of the second	Funeral Director		5. Social Security Number 219–10–1037	6. Sex 1 ☐ M 2 🖾 F	7. Age	e (In yrs. last birthda 4 Yrs	Months	Days	If Unde Hours	Min.	8. Date of (Month	of Birth h, Day, 1	Year) 1923	9. Birth Cou Wash	place (State ntry) ingto	or Foreign n, DC
	pu ,		Usual Residence of Decedent  10a. State 10b. County			10c. City, Town or	Location								10d. Inside (	City Limits
	ne Maryla 8a-f shov ptified at	ector	Maryland Prin	ce Georg	e's	Colleg	e Parl					100	g. Citizen of	What Cou		s 2□No
	th with the 23a or 2 ust be no	Funeral Director	10e. Street and Number 9605 49th Aver					p Code 2074					USA			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	y Fune	11. Marital Status  1 □ Never Married 2 □ Marrial 3 ☒ Widowed 4 □ Divorced	ried Armed 1 ☐ Ye	Forces? s 2⊠1 Give	Ever in U.S. 1	3. Was Dece If Yes, spe 1 ☐ Yes		ispanic O an, Mexica Specify		pecify Yes on Rican, etc	or No- :.)		ck, White,	can Indian, etc. ucasi	an
Ş	2 hour atural	ed t	15. Deceden	t's Education		16a. De	cedent's Usi	ual Occup	ation		Life a	10	6b. Kind of E	Business/Ir	dustry	
21215	I within 7% jene. r than "n the Medi	Completed by	(Specify only higher Elementary/Secondary (0-12) 12		d) (1-4or 5		ive kind of w e. DO NOT i omemak		during mo	ist of work	KING		Own	Home	2	
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Baltimore,	es 1 a of He of He ritem	1 3	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Domeyal fra	m Stata	20b. Place of Di cemetery,	sposition (Na crematory or	ame of other plac	ce)		Date	1	0c. Location	•		
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alt	permit. Departr Importa any Inf		21. Signature of Funeral Service	Licensee	,	.1 .	22. Name a				ma D	Δ			imore	
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Ì	Physician /Medical Examiner		23a. Part. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Ce	rebr to (or as	ovascular a consequence of):				·	, or respirat		O.,		Approxim Interval B Onset an	etween d Death
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c 687	certificate iding physise as the	Med	IF FEMALE:						-							
D. Box	00	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Liv 4□Pr	e birth	pf pregnancy 2 ☐ Fetal death t time of death	3 □Ectopic 5 □ Other (		у					ate of deli	ery Day	Year
P.0	requires that the de een signed by the a nould be detached f	, Ph	Part II. Other significant conditi	ons contributing to	death b	ut not resulting in th	e underlying	cause giv	en in Par	t I.	23e.	Did toba	acco use co	ntribute to	the cause o	f death?
ds	es De	d by										1 🗆 Ye	s 2 <mark></mark> ∏ No	3 □ Pro	bably 4[	Unknown
Records,	e law has b	Completed										Was an autopsy perform	ned?	death?	opsy finding ompletion o	s available cause of
E			25. Was case referred to medica	al .	_				26 Pla	ce of Dea	ath (Check		No No	1 ∐ Yes	2□ No	
or Vital		To Be	examiner? 1 ☐ Yes 2 🔀 No	Hoenital:	☐ Inpati	ent 2 ☐ ER/Outpa	tient 3 □ □	OA Oth					nce 6 □0	ther (Spec	ify)	
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Division	Il or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could 4 Homicide deterr	ningd   200. Pl	ace of inj ilding, e	ury - At home, farm c. (Specify)	, street, facto	ory, office			28f. Loca City	tion (Str or Town,	eet and Nur , State)	nber or Ru	ral Route N	umber,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifyi (Check only one) 2 Medica	I Examiner: On th	the best e basis o anner st	of my knowledge, of examination and/ ated.	eath occurre or investigation	ed at the to	me, date opinion, d	and place leath occi	e, and due urred at the	to the ca	ause(s) and i	manner as e, and due	stated. to the caus	e(s)
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	_		1	M ms				55	5559	1			-	ARZ	25,	2008
	5 Y		30. Name and address of person Thomas E. Mas	who completed clen, M.D.	ause of c	death (Item 23a) (Ty 525 Green	<sub>pe, Print)</sub> way Ce	nter	Driv	ve, (	Greent	elt	, MD 2	20770		

State Registrar

EFFrem Kearney
08-00551 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NK UNK		State of Maryland / Departm	nent of cate of a		and I	Mental		0	00	0 0000
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)		Douth			2. Date of De	Reg. No.	44	3. Time of Death
Friysicia ledical Examii		EFFREM D. KEARNEY					Month January	Day Year 19, 2008	.	2310 hrs
		4a. Facility Name (if not institution, give street and number)	41	c. City, Tov	vn, or Loc	cation of De		4c. County o	f Death	
		Johns Hopkins Hospital		Baltimo	re					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi	irthday)	If Under	1 Year	If Under 24	Hrs. 8. Date of E	Sirth (MM/DD/YYYY)	9. Birt	hplace (State or n MARYLAND
Director		219-13-2854 XXM 2 F 20	Yrs.	Months	Days	Hours	Min. 02/0	2/1987		n MAKILAND
		Usual Residence of Decedent	113.				02/0	2/1507	<u></u>	
any		10a. State 10b. County 10c. City, Tow	n or Locatio	n						10d. Inside City Limits
ž .	_	MD N/A BALTI	IMORE	CITY						1XX Yes 2 No
Aaryland 28a-f show 1 at once.	용	10e. Street and Number	- 1	10f. Zip C	ode			10g. Citizen of Wh	at Cour	itry?
th the Maryland 23a or 28a-f sho notified at once.	Director	2878 HARFORD ROAD			2121	8		USA		
vith the s 23a		11. Marital Status 12. Was Decedent Ever in U.S.	13. Was				( Specify Yes or N		- Ameri	can Indian, Black,
ath v	Funeral	1 X Never Married 2 Married Armed Forces?					erto Rican, etc.)	White	, etc.	
ter de		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 7	Yes 2X	No s	specify:		Specify:		BLACK
urs af tural amin	d b	or Dates:					of work done	16b. Kind of Bu	siness/I	ndustry
72 hor	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	st of working	ng life. Do	O NOT use	retired)	ľ		
136 thin 3	ompleted	10'TH	C	USTO	DIAN			SCHOOL	SYS	TEMS
5-0( ed wi lygier other	S	17. Father's Name (First, Middle, Last)			18.	.Mother's N	ame (First, Middle	, Maiden Surname	,	
21215-0036 uld be filed within 7. Mental Hygiene. marked other than c event, the Medial	Be	EFFREM KEARNEY					HA MCCAL			
	10							umber, City or Tow		
MD id 2 sho lith and m 27 is aumati		MIKISHA MCCALL / MOTHER					Date Date	LTIMORE,		
s l ar of Hez If iter		4 V Buriel 2 Cromotion 2 Removed from State Cremi	of Disposit atory or othe	er place)		l l			-	
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Baltimore, permit. Pages 1 an Department of He. Important: If ite		21. Signature of Funeral Service Licensee	22. Na	me and A	ddress of	f Facility	HOWELL F	UNERAL H	<b>OME</b>	21207
<b>m</b> 80 a.e.		Whype O' Dury	46	500 L	IBER	TY HE	CIGHTS AV	E, BALTII	MORE	
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lox 6 leath cer e attendi for use	sici	4 Pregnant at time of death	5 Oth	er (Specif	y)			Ì		
he des	Phy	Part II. Other significant conditions contributing to death but not result	ing in the ur	adorluina o	ouco div	on in Part t	23e Did	tobacco use contr	ibute to	the cause of death?
res that the signed by	β	Part II. Other significant conditions — contributing to death but not resolu	ing in the di	idenying c	ause give	CHIIII CILL				pably 4 Unknown
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of Vital Records, in Physician: The law require this certificate has been simeral director, page 2 should be	Completed						aut	opsy		completion of cause of
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ion frend leath. for:	aţic	2 Accident Investigation				s 2 🗹 No				
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Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the beauthed for the funeral director.	Certification:	4 Homicide determined (Specify) Local Street	_		_			ook Street, Baltin		
re Ho n 24 h re Fur letely		29a. Certifier (Check only one)  Quantifier 1 Certifying Physician: To the best of my knowledge, d (Check only one)  Wedical Examiner: On the basis of examination and/o	leath occurr	ed at the ti	me, date	and place,	, and due to the ca red at the time, da	iuse(s) and manner te and place, and c	as stat	ed. ne cause(s)
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	and manner stated.	vesuyati		License r					nth, Day, Year)
	Σ	29b. Signature and title of certifier						January 20	•	
		my mis			O.C.M.	.c.		January 20	·, ∠00	
3		30. Name and address of person who completed cause of death (Item 23a	nn Street	+ Dalties	oro NA	D 21204				
					UIC, IVI					
St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 29 2008 32. Projetrar's Signature	A sale	3482						

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Margaret Linda Ko		r - For State	St	ate o	of Maryla	ind / Depa	artment o rtificate o			d Ment	tal Hyg			0	20.0	n n	0001
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12-	H	4a. Facility Name (i				mber)		4b. City	, Town, or	Location o			1	4c. County	of Death		
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Funeral		5. Social Security N	lumber	6. Sex		7. Age (In yrs.	last birthday)		nder 1 Year			8. Date of I	Birth(MI	M/DD/YYYY		nplace (State	
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5-0036 led within 7 Hygiene. to other than		17. Father's Name	(First, Middle	, Last)			1 01.			18.Mother	's Name (F	irst, Middle	e, Maide	en Surname	:)		
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Division of Vital Records, P.O. Box 6876 to a or Attending Physician: The law requires that the death certificate rs after death.  al Director: After this certificate has been signed by the attending phy and in by the function, page 2 should be deaded for use as the feath by the function.	-	27. Manner of Deat			28a. Date	of Injury n, Day,Year)	28b. Time of	f Injury	28c. Inju	ry at Worl	k? 2	8d. Descri	be how	injury occur	red		
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DHMH 17 Rev 1/2001 OCME 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 08 **Physician** Margaret roiman 20 0 /Medical 4a. Facility Name (I) not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Bultmore Baltimore City If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Funeral Days Yrs. 214-50-9883 1949 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County or 28a-f show a notified at 1 ☐ Yes 2 No **Baltimore** Catonsville Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a or Examiner must be r 21228 1912 Tadcaster Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Yes 21 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 Divorced natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Healthcare **Registered Nurse** the 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last, Be and Mental E. Mildred Cutsail Mark J. Golibart ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12908 Triadelphia Rd. Ellicott City, MD 21042 Health tem 27 i Jay Golibart 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of h Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Frederick, MD 4 Donation 5 Other (Specify) Mt. Olivet Cemetery Sign ture of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 17223 4 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirators arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Humor hagic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Curhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine CERTIFICATION g physician and Down The law requires that the death certificate be executed full Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a detached f 2  $\square$  No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed | 2 No 3 Probably 4 Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I perform 2 🗆 No 1 Yes certificate To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral 5 Pending investigation 1 🗆 Natural Injury 1 🗌 Yes 91200 2 No unknowim 2 Accident er or Rural Route Number, Could not be determined ation (Street and Numb or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location 2 Tad caster 4 Homicide tonsu Kesikehce 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature, and title of certifier

Registrar

State

30. Name and address of person

31. Date filed (Month, Day, Year)

Ki

JAN 29

Baltmore, ell

who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1:40P M Month aã 2008 Vorena 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Care Baltimore Cauton Harbon 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign If Under 24 Hrs If I Inder 1 Vear 6. Sex Days Min. Months Hours 1 □ M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Pres 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number able E. Federal aiai3 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Black 1 Yes 2 ANO 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1) omestic omestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) enny Vincent Underdue Ananais 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. 2616 E. Federal St Baltimore, MD 21213 grolyn Lashley/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1.29.2008 Baltimore, MD Oaklawn Cemeter 4 □ Donation 5 □ Other (Specify) of Facility Vaughon C Greene French Services 21. Signature of Funeral Service Licensee 22. Name and Address 4905 York Ad Baltimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Oa Immediate Cause (Final disease or condition resulting in death) C mou Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

other than

and Mental is marked

other traumatic event, the

Department of Health a Important: If Item 27 Is any injury or other trau

Director

Funeral

Completed by

Be

filed within 72 hours after death with the Maryland I Hygiene.

Baltimore, Maryland 21215-0036

Physician/Medical Examiner the burial-tran and attending physician for use as the buria been signed by the s should be detached à page 2 s certificate director. Certification: To this uneral After within 24 hours aner common to the Funeral Director: Aft

The law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

the Hospital or Attending Physician:

101

IF FEMALE: in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 25. Was case referred to medical examiner? Be

1 Yes 2 No

27. Manner of Death

1 Natural
2 Accident

3 Suicide 4 Homicide

29a. Certifier

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

3 Probably 4 Unknown 2 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 No

26. Place of Death (Check only one) Other: Hospital: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3∐ DOA 1 Inpatient 2 ER/Outpatient 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of (Month, Day Year) Injury

5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

ss of person who completed cause of death (Item 23a) (Type, Print) 30. Mame and

Ma

31. Date filed (Month, Day, Year) 2 JAN 9 2008 32 Registrar's Signature

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month <sup>Day</sup> 28 **Physician** 5:30 p <sup>M</sup> 2008 January Frederick Lewison Edward /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore 4100 N. Charles Street, #501 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1**X** M 2□F Illinois FEB 11 1913 94 Director 214-40-1595 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 Yes 2 No ral", or items 23a or 28a-f sh Examiner must be notified Director N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with USA 21218 4100 N. Charles Street, #501 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Armed Forces: 1 ★ Yes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1∐Yes 2AM No Baltimore, Maryland 21215-0036 Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Medical r than " Elementary/Secondary (0-12) College (1-4or 5+) **Healthcare** Surgeon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event once. Be Julia Trocki Maurice Lewison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4100 N. Charles Street, #501, Baltimore, MD Betty F. Lewison - Wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metro Crematory, Inc. 1/29/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Steven H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Myelodysplastic syndrome
Due to for as a consequence of): Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine nding physician and use as the burlat-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 【X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2₺ No 24a Was an autopsy performed?
Yes 2 X No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 TResidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Fype, Print) 2011 Balt, MD 1025 ROSS RuHand 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Depar State of Maryland / Depar Certification	ificate of Death		eg. No. 🤈 🗎 🗎	1 02080
	Physicia		1. Decedent's Name (First, Middle, Last)  GARY NUMSEN LUCKE		2. Date of Dear Month	th Day Year	3. Firme of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Dear	
-	Funeral		S. Coolai Goodiny Hambol	BALTIMORE If Under 1 Year   If Under 24 Hr	S. 8. Date of Birth	9 Birl	hplace (State or Foreign
	Director		214-56-1884	Months Days Hours Mir	Sept 22	4,1950 Mic	higan
	yland now		10a. State 10b. County 10c. City, Town or Loca	ition			10d. Inside City Limits
	he Mar 8a-f sk otiffied	ector	Maryland Anne Arundel Annapol	.is		log. Citizen of What Co	1 □ Yes 2 No
	3a or 2	al Dir	10e. Street and Number 29 West Washington Street Apt. 409	21401		USA	unity:
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmportant: I flem 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 Never Married 2 Married 1 Nes 2 No 12/0	as Decedent of Hispanic Origin? ( Yes, specify Cuben, Mexican, Pue ☐ Yes 2X No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
20-0	72 hou natura Ilical E		15. Decedent's Education 16a. Deceder (Specify only highest grade completed) (Give kii	nt's Usual Occupation ind of work done during most of w O NOT use retired)	orking	16b. Kind of Business	Industry
7	within ene. than " he Mec	Completed	Flementary/Secondary (0-12)   College (1-40r.5+)   1	o NOT use retired) uck Driver		Trucking	
20	be filed tal Hyg d other event, t	Be	17. Father's Name (First, Middle, Last)	1	ame (First, Middle,		
7	should od Men marke imatic	To	William Lucke  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing	Address (Street and Number or F	othy UNK Rural Route Numbe		Zip Code)
, Ma	and 2 sealth ar			lest Friends Roa			
	ages 1 int of H t: If iter y or oth		20a. Method of Disposition  1 Burial 2 X remation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposit cemetery, crema		Date 28/08	20c. Location - City or Baltimore,	
Dallillo	permit. P Departme Importan any injur		21. Signature of Funeral Service Ligersee 22	Name and Address of Facility Fremation Societ 199 Frederick Ro			
0	8 9 E E 8					<del>-</del>	Approximate
F	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition VARICEAL BLOG				Interval Between Onset and Deeth
E ·	/Medical Examiner		Due to (or es a consequence of):				
b	<b>朱</b> 寶	ner	Sequentially list conditions, if any leading to immediate Due to (or es a consequence of):				
	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
00/00	te be e; ysician ie buria	edical E					
00 X	ertifica ding ph		IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of de	ivone
O. DOX	The law requires that the death certificate be executed tee has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	in the pact 13 months?	Ectopic pregnancy Other (specify)		Month	Day Year
'n	es that gned by se deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the und	lerlying cause given in Part I.		bacco use contribute to	
cords,	aw requires that s been signed t s should be deta				1		obably 4 Monknown utopsy findings available
ב	The law te has t age 2 s	Completed			- autop	sy prior to death?	completion of cause of
ומ	ding Physician: The I h. After this certificate ha funeral director, page	Be C	25. Was case referred to medical examiner?  Hospital:	Other	eath (Check only or	ne)	
5	g Phys er this c eral dir	n: To	27. Manner of Death 28a. Date of Ingry 2 28b. Time of	3 □ DOA Utter: 4 □ Nursing  28c. Injury et Work?	1	ence 6 □Other (Spe ow injury occurred	cify)
	tending eath. tor: Aft the fun	catio	1 Natural 5 Pending (Montin, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, stree	M 1 ☐ Yes 2 ☐ No	Opt Leastion (C	treet and Number or R	ural Bouto Number
2	al or At after d Direct d in by	Certification:	4 Homicide determined building, etc. (Specify)	a, lactory, office	City or Tow		graf House Warnber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director; t	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investant and manner stated.	occurred at the time, date and pla estigation, in my opinion, death oc	ce, and due to the courred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier  Norm—F. (2	29c. License number	2	29d. Date signed (Mon	
	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Pi			01-26	
l			NORMAN RETENER MD 10 N. GREE		imort i	MD 21201	

DHMH 17 Rev 1/2001

Registrar

JAN 2 9 2008

ORIGINAL

him to provide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Mary Lee LaMotte January 26, 2008 12:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan 5, 191 9. Birthplace (State or Foreign Country) North Carolina Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2XF 93 219-76-3620 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Baltimore Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 615 Chestnut Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: White Specify. Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Health and Mental Hygiene. College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( 99 Frank E. Mountcastle Frances Bradley 2 Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4004 Linkwood Road Baltimore, Maryland 21210 Nancy Lee LaMotte, Daughter Department of Heali Important: If Item 2 any Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 01/28/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Herry Thorax **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregrant in the past 12 months?

1 Yes 2 DNo 3 □Ectopic pregnancy for Month Day 5 Other (specify) 4☐Pregnant at time of death ed by the a 9□Unknown 9 Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be linger row 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an performed? Yes 2 No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation fail January 23, 2008 unknown M 1 ☐ Yes 2 No 2 Accident after death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Tuhingul Miremen moun (y Hospital 24 hours a e Funerail 1 Certifying Physician: To the bestor my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical within 24 ho

To the Function 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated. 29d. Date signed (Month, Day, Year) JAN 26, ED 8 29c. License number 29b. Signature and title of certifier 30. Name and address of per who completed cause 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 9 2008 Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mar		artment of H rtificate of I			giene Reg. No. 2 (	008	02091
	Physic /Medi		1. Decedent's Name (First, Middle, La	Stuart L.	Loats			2. Date of Dea Month	ath Day 2.3	Year 2008	3. Time of Death
	Examii		4a. Facility Name (If not institution, giv Union Memorial Ho	· ·		4b. City, Town, or Baltir	r Location of Death		4c. Coun	nty of Death	
	Funeral Director			ex 7. Age (I	In yrs. last birthday) 67 <sup>Yrs.</sup>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 3 - 3	h y, Year) <b>–1940</b>	9. Birthpl Count Mary	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	rector	Usual Residence of Decedent  10a. State  10b. County  MD  N/A  10e. Street and Number	10	Oc. City, Town or Lo				10g. Citizen o		0d. Inside City Limits
	r death with lems 23a or er must be	Funeral Director	1329 W. 37th S	treet 12. Was Decedent Eve	er in U.S. 13.		211 ispanic Origin? (Span. Mexican, Puert		14. Ra	JSA ace - America ack, White, e	an Indian,
215-0036	hours afte atural", or if	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ♣ Divorced  15. Decedent's Ed	1 ★★ es 2 ☐ No If Yes, Give Year or Dates:	16a. Dece	1 □ Yes 2√21√No	Specify:		Spec	eify: V	white
21	ed within 72 ygiene. ier than "nat, the Media	Completed	(Specify only highest graves) Elementary/Secondary (0-12) 12	de completed)  College (1-4or 5+)	(Give	kind of work done of DO NOT use retired at Cutter	during most of word ()	king		od Mar	,
Maryland	rould be file i Mental Hy narked oth	To Be (	17. Father's Name (First, Middle, Last) Unknown				18. Mother's Nam Unknown				
	1 and 2 sh Health and em 27 is n		19a. Informant's Name/Relationship ( Susan Edwards  20a. Method of Disposition	Fiancee		w. 37th S	treet	ral Route Numbe Baltimor Date		yland	21211
Baltimore,	nit. Pages vartment of ortant: If It Injury or o		1 Burial 2XX remation 3 4 Donation 5 Other (Specifical Signature) of Funeral Service Dicer	Removal from State	metro C	rematory or other place rematory 2. Name and Addres	1/25	/2008	Catons	ville,	Maryland
Ba	permi Depar Impor any Ir		23a. Part1. Enter the disease, or comshock, or heartfailure. List only	entre		Burgee- 3631 Fa	Henss-Se lls Road	itz Fune Baltin or respiratory an	eral Ho nore, M rest,	me, Ir D'212	Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a co	Stude	cop	D				Interval Between Onset and Death
6	range al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Du to or as a co	100	Hation				1	> 18 day
k 68760,	ertificate be executed ing physician and as the burial-transit	dical	IF FEMALE:	.d							
P.O. Box	Physician: The law requires that the death certific this certificate has been signed by the attending p ral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf p 1□Live birth 2 □ 4□Pregnant at tim 9□Unknown	∃Fetal death 3 ☐	Ectopic pregnancy Other (specify)				ate of deliver lonth	ry Day Year
	w requires that been signed I should be det	þ	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the ur	nderlying cause give	en in Part I.		bacco use cor es 2 □ No		e cause of death?
or Vital Records,	ician: The law certificate has b ector, page 2 sh	Completed						24a. Was a autop perfor 1∐ Yes	sv	. Were autop prior to com death? 1 ☐ Yes 2	esy findings available inpletion of cause of
ion or Vii	nding Physician: ath. r: After this certific ie funeral director,	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	Hospital: 1 Xinpatient 28a. Date of Injury (Month, Day Ye	t 3 DOA Other	4 LI Nursing Ho	h (Check only or ome 5 Resid 28d. Describe h	ence 6 □Ot		)	
Division	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - building, etc. (S	Specify)			28f. Location (S City or Town	n, State)		
	the Hosp in 24 hou the Fune ipletely fil	edical	one)	sician: To the best of m iner: On the basis of exa and manner stated	amination and/or inv	occurred at the time vestigation, in my op	ne, date and place, pinion, death occur	and due to the d red at the time, d	eause(s) and π date and place	nanner as sta , and due to	ated. the cause(s)
	vit To	Σ	29b. Signature and title of certifier	MD		29c. License	2 h 3 8		Jan		Day, Year)
_	10		30. Name and address of person who c	rih MD.	unio		morrial	hos	pita	(	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Pogistrar's		asale					

DHMH 17 Rev 1/2001

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			1 - For State Registrar	State of	Marylar		artment of F rtificate of		l Mental Hy				
			Decedent's Name (First, Middle, L.)	ıst)			inicate of	Death	2. Date of De		2000	3. Time	Of Death
	Physic /Medi		Mary E	lizabeth	n Lynch				Jan 22	. 20	y Year 108	8:36	<b>Д</b> М
	Examir		4a. Facility Name (If not institution, gi		nber)		4b. City, Town, o			4c	. County of Death		
			St. Thomas Nursi 5. Social Security Number 6.		7 Age (In une	lo at hinth days	Hyattsvi	LLE If Under 24 H	ro 10 p. i		Prince G	_	
L	Funeral Director		130 28 2395	1 M 2 F	7. Age (In yrs. 72	Yrs.	Months Days	Hours Mi		ay, Year)		place <i>(St</i> ate intry) York	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside 0	City Limits
	Mary -f sho fied a	to	Maryland Prince G	oorgota		Clinto	_						s 21/21/No
	th the or 28a e noti	Director	10e. Street and Number	0		CITILLO	10f. Zip Code			10g. Cit	tizen of What Cou	ntry?	
	ath wi	ral	9301 Foxo				2	20735		Un	ited Sta	tes	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Dece Armed For 1 ☐ Yes If Yes, Giv Year or Da	ces? 2. No eXX		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☐√No	ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	0~	14. Race - Ameri Black, White, Specify: Bla	etc.	
9	72 hou nature ical E	ted	15. Decedent's E	ducation	-		dent's Usual Occup			16b. K	(ind of Business/Ir		
21215-0036	within 7 iene.  than "r	Completed by	(Specify only highest gr	College (1-	4or 5+)	Homer	kind of work done o DO NOT use retired Naker	during most of w f)	vorking	Ow	n Home		
Maryland 2	ild be filed lental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle, Las Cleofe Troncos			1		18. Mother's N Alici	ame (First, Middle a Marti		n Surname)		
ary	shou and N s mar	-	19a. Informant's Name/Relationship			19b. Mailin	ig Address (Street	and Number or	Rural Route Numb	per, City o	or Town, State, Zi	o Code)	
Σ, Σ	is 1 and 2 of Health a litem 27 is other trau		Mark Lynch (So	n)			Foxcroft			MD 2	0735		
Baltimore,	ages 1 ent of H t: If ite y or ot		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Speci		nate į		sition (Name of natory or other plac	1	Date		ocation - City or T		
≡ Ei	mit. Partme		21. Signature of Fun I Service Lice		r.e.	e Crema	atory Ja . Name and Addres	n 27. 2	008   e Funera	1 Hor	inton, M		d
<u>~</u>	Ber any	F	MADL		10015		. Name and Addres Lexandria				n,'MD 2	633_01 0735	.u
>	Physician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. Arte	used the deat ich line. or as a conseq	lach	er the mode of dyin	g, such as cardi	ac or respiratory a	rrest,	se	Approxima Interval Be Onset and	etween
68760,	ficate be executed physician and is the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):										
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Records, P.	w requires that the de been signed by the a should be detached to	þ	Part II. Other significant conditions  End Stage 1	Contributing to dea		-	iderlying cause give	en in Part I.	23e. Did t		use contribute to t ☐ No 3 ☐ Prol		death? Unknown
_		Completed	1 type ten	.CICA			<u>-</u>		24a. Was autoj perfo 1∐ Yes		death?	psy findings mpletion of c	available cause of
Vital	cian: ertific ector,	Be (	25. Was case referred to medical examiner?						eath (Check only o		, , , , , , , , , , , , , , , , , , , ,		
or	Physi this c	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ In		ER/Outpatient		4 La Nursing	Home 5 ☐ Resi			fy)	
ono	ding h. After funer	tion	1 ■ Natural 5 □ Pending	(Month	, Day Year)	28b. Time of Injury	28c. Injury Work M 1 □ \	rat :? Yes 2 ∐ No	28d. Describe	how injur	ry occurred		
Division or	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director; I	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	28e. Place o	f injury - At ho g, etc. <i>(Specif</i> )	ome, farm, stre	eet, factory, office	res ZINO	28f. Location (S City or Tox	Street an wn, State	nd Number or Rure e)	al Route Nur	nber,
	he Hospitt n 24 hours he Funera pletely fille	Medical C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example	nysician: To the base miner: On the base and manne	sis of examina	wledge, death tion and/or inv	occurred at the time vestigation, in my of	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s)	) and manner as s d place, and due t	stated. o the cause(	s)
	To t To t	Σ	29b. Signature and title of certifier	17	1		29c. License				te signed (Month,	-	
•	<sub>Λ</sub>		Handle	nder	nec	w	20	1850	۷ .	TAN	VUARY	222	008
	1		30. Name and address of person who	VORE	of death (Item	ا (Type, F کنے کا	DO Print)	BUREIK	d /140	ilts	wille M	120	701
	Sta Registra		31. Date filed (Month, Day, Year)	008 32/6	gistrar's Signa	ture	2421						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Irvin Bernard Lawson State of Maryland / Department of Health and Mental Hygiene 2008 02093 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Irvin Bernard Lawson **Medical Examiner** 0130 hrs January 25, 2008 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) MD 220-72-6049 Months Davs Hours Director 1 X M 2 F 31 Nov. 22, 1976 Yrs Usual Residence of Deceden iny 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore or 28a-f show 1 X Yes 2 or items 23a or 28a-f shomust be notified at once. death with the Maryland Director 10e. Street and Number 3802 Evergreen Avenue 10f. Zip Code 10g. Citizen of What Country? 21206 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc 1 X Never Married 2 2 X No African American Yes Yes 2 XX No specify: If Yes. Give Year Widowed 4 Divorced Specify: "natural". ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry altimore, MD 21215-0036
mit. Pages I and 2 should be filed within 72 hou warment of Health and Mental Hygiene.
ortant: If item 27 is most 1. Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Medical 11 cook McDonald's 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Irvin B. Lawson, Sr. Alice Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Oaks / Mother 3802 Evergreen Avenue; Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, 20c. Location - City or Town, State crematory or other place) 1 XX Burial 2 Cremation 3 Removal from State 02/01/2008 King Memorial Park Randallstown, Maryland Donation 5 Other Specify 22. Name and Address of Facility Wylie Fumeral Home, P.A. 21. Signature of Funeral Service License 638 N. Gilmor Street; Baltimore, MD 23a. Part I. Enter the disease, or complic tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each /Medical Death a, Multiple Gunshot Wounds Immediate Cause (Final disease raminer Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Examiner Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical g physician a the burial -UNPENDED AMENDED requires that the death certificate be O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, P. 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of The law this certificate has performed? death? ✓ Yes 2 1 🗸 Yes No 2 No Physician: 25. Was case referred to medical Division of Vital 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other: 1 ✓ Yes No After t 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospital or Attending hin 24 hours after death. Subject shot Natural **FOUND** Director: Pending 1 Yes 2 ✓ No Jan 25, 2008 0041 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 901 Pennsylvania Avenue , Baltimore, MD determined To the Funeral (Specify) Local Street 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

1

State Registra

one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Lina Li. MD 31. Date filed (Month, Day, Year,

2 8 2008

2. Registrar's Signature

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 25, 2008

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State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Betty Evelyn Lowe 8:43 PM Jan 24, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Catonsville 6308 Frederick Rd. If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 □ F 112-L14-L840 Usual Residence of Decedent Yrs. Director 62 r 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Catonsville MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 21228 Examiner must Funeral 6308 Frederick Rd. Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within ? h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Shoemaker ည Robert Leroy Byrns 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or other traum 3004 Westchester Ave. Ellicott City, MD 21043 daughte Christine Healey 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) Jan 29, 2008 Ellicott City, Maryland **Good Shepherd Cemetery** 21. Signature of Funeral Santo Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metrotatic brat can con **Physician** 4 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No has page 2 certificate 1□ Yes 2☑No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 **N**0 မ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 740850 January 28, 2008 Oth 1 30. Name in address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar OTTAVIANO

9 2008

31. Date filed (Month, Day, Year)

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9103

32. Registrar's Signature

DHMH 17 Rev 1/2001

FRANKLIN SQUARE DR. BALTIMORE

21237

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 22 8:30a M 01 Ε. Moore Mildred /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 4008 Garrison Blvd If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 1 F Director 34-22-4912 82 0.3 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits and Mental Hygiene. I and Mental Hygiene. I is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director MD NΑ Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U • S • A Pages 1 and 2 should be filed within 72 hours after death 21215 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerio Rican, etc.) 4008 Garrison Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade New York Years Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Irene, Payne Clarence, Plummer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 Is any Injury or other trauonce, Delzora Felipa-Hale 4010 Garrison Blvd Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Calverton National Cemetery 1/29/08 Calverton, NY 22. Name and Address of Facility March F/H West 21. Signature of Funeral Service Lice 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and s the burial-transit Division or Vital Records, P.O. Box 68760, fuilore Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ed by the a 9 Unknown buting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be o 1 🗌 Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an page 2 s autopsy certificate 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Medical Certification: To Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 25 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation ours after death. neral Director; A filled in by the fu 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

To the Hospital or Attending Physician: within 24 hours a

To the Funeral I

completely filled

and manner stated.

9

State Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 839 M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of De **Examiner** rundel (200) Year If Under 24 Hrs. Security Number Age (In yrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🕱 F Hours Min. مي **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Directo ANNE ARUNDED 10e. Street and Number 10g. Citizen of What Country? NES "natural", or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ZNNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12+11GRADE 17. Father's Name (First, Mjddle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important; If ite any injury or ot once. 1X Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirating arrest, shock, or heart failure. List only one cause or leach line. Immediate Cause (Final 15845 Physician 1205C disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Dunknown 1 🔲 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Was a. autopsy performed? certificate has b irector, page 2 sl 24a. Was an funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Xes 2 No 1 Inpatient 2 BR/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Iniury 1 Natural 1 Tes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

To the Hospital or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours a

To the Funeral I

completely filled

State

DHMH 17 Rev 1/2001

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 2 2008 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar Richard Feldman

31. Date filed (Month, Day, Year)

JAN 2 9 2003

32. Registrar's Signature

9500 Annapolis Rd., Suite A4, Lanham, MD 20706

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year Melhor 24 E. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Parking. Balfore CTEMOSIS Yerring Parkuille If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 2 7 F 99 Yrs. Director 216-28-8921 4-17-1908 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2/5/No Baltimore Parkville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 2 Genesis- Perring Parkway 21234 Funeral 1801 Wentworth Way 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or item edical Examiner r Black, White, etc. 1 Yes 27No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XXNo Specify Completed by Specify: 3√√Vidowed 4 □ Divorced white Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 94 Hutzler's Dept. Store Seamstress 8th marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) in and 2 should be fill Health and Mental H tem 27 Is marked ott Be David Frank Oberdier Emma Jane Snelbaker ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Pages 1 and ... rtment of Health an Louise Warehime Daughter 1919 Haverhill Road Parkville, Maryland 21234 Item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State <u>-</u> 5 Important: If any injury o Lorraine Park Cemetery 1/26/08 Woodlawn, Maryland 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Physician Alzeheimers disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the sequence of the Examiner Due to (or as a consequence of) and % The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ₺ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Gerd 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2. No certificate 1□ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this the funeral 28a. Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural 1 🗌 Yes 2 🗍 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending within 24 hours after death. To the Funeral Director; A

29b. Signature and title of certifier

MO D31295 Klas 124/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 Horth Charles St Suite 4202 7 cm son 21204 KIRRSZ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death January 24, 2008 **Physician** 9:35 A. M Ruth T. Moncure /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Rethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec. 10, 1927 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🔀 F West Virginia 80 213-26-9534 Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 X No Director Rockville Maryland Montgomery 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? be United States 8111 Jeb Stuart Road 20854 or Items 23a **Examiner must** Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. within 72 hours after 1 ☐ Yes 2 A No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 ☑ Widowed 4 ☐ Divorced "natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph E. Thompson Ella M. Olcott ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert T. Moncure / Son 8111 Jeb Stuart Rd., Rockville, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cametery crematory or other place)
Aquia Episcopal
Church Cemetery 1 Buriai 2 □ Cremation 3 □ Removal from State Jan. 30, 2008 Aquia, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Pervice Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line. Immediate Cause (Final Physician Septic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed: colitis 1∐Yes 2∏ No 1□ Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Certification: To after death.

I Director: After this of in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

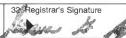
Box 68760.

Division or

State

Registrar

31. Date filed (Month, Day, Year) JAN 29



MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hossein Akhondi Asl, M.D., 8600 Old Georgetown Rd., Bethesda, Maryland 20814

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	Physici		1. Decedent's Name (First, Middle, Las Catherine Naomi M	·						2. Date of De Month  Januar	D	Year 6, 2008	3. Time of Death 10:30 A	vI
)	/Medic Examin		4a. Facility Name (If not institution, give Rockville Nursin		ar)		4b. City, Town, C	r Locatio		Januar		4c. County of Death  Montgomery		
	Funeral Director		5. Social Security Number 6. S		Age (In yrs. last bii	rthday) Yrs.	If Under 1 Year Months Days		er 24 Hrs.	8. Date of Bir (Month, Da Feb. 2	th ay, Yea	1915 Vir	hplace (State or Foreig untry) ginia	חק
Idryidna Z 1 Z 1 3-UU30 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgome	ry	10c. City, Tow		.e						10d. Inside City Limits		
	th with the 23a or 2 ust be no	ral Dire	10e. Street and Number 300 Park Road				10f. Zip Code 20850	)				Citizen of What Co Lted Stat	•	
ING Z IZ I 3-UU30 be filed within 72 hours after death with the Marylan tial Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	urs after dea al", or items Examiner m	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decede Armed Force 1  Yes 2 If Yes, Give Year or Date:	s? <b>X</b> No		Vas Dec <i>e</i> dent of F f Yes, specify Cub I □ Yes 2🏋 No			ecify Yes or No Rican, etc.)	)-	14. Race - Ame Black, White Specify: Wh		
1 Z I 3-UU36 vithin 72 hours af ne. han "natural", or e Medical Exami		Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 1 2	lucation de completed) College (1-4c	or 5+)	(Give life. L	lent's Usual Occup kind of work done DO NOT use retire	pation during m d)	ost of worki	ng		Kind of Business/	Industry	
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<u> </u>	d Ment marked matic	ဥ	Robert Lee Dick  19a. Informant's Name/Relationship	Time (Print)	106	Mailin	a Address (Ctrast	L		i Snepe		or Town, State, 2	7'- O- 4-1	_
re, Maryla s 1 and 2 should f Health and Mer item 27 is marke other traumatic			Richard Allen Mil				Rolling						up Coae)	
<b>Dalumore,</b> permit. Pages 1 ar	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trau		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specifi	Removal from Sta	te Rocks	f Dispo	sition (Name of natory or other pla	ce)	Janu 31	ary 2008	20c.	Location - City or	MD	
סמונ	permit. Departr Importa any Inju		21. Signature of Funeral Service Licen	see	M01346	RC S RC	Name and Addre	ss of Fac	300	ert A. West N	Pun Iont	nphrey Fu gomery A	ineral Home venue	:7
,00/00	Physician // Medical Examiner and // Physician and // Phy	edical Examiner	23a. Part1. Enter the disease, or companies shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Pneumon Due to (or a	ensive He as a consequence nia as a consequence atory Fai as a consequence	eart of): of):	Disease		as cardiac o	r respiratory a	irrest,		Approximate Interval Between Onset and Death	
O. DOX 00	The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		2 Fetal death		Ectopic pregnanc	у			i	23d. Date of del	ivery Day Year	
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חבפעו	The law rec ate has beel page 2 shou	Completed								24a. Was auto perfo	psy ormed?	prior to death?	topsy findings availabl completion of cause of 2 ☐ No	e
<u> </u>	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			t 3D DOA Oth			(Check only	one)			_
VISIOII OF	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to the property of the funeral director, page 2 to the funeral director.	ition: To	1  Yes 2  No  27. Manner of Death 1  Natural 5  Pending 2  Accident investigation	28a. Date of In (Month, I		itpatien Time of Injury	28c. Inju	414	1	me 5 ☐ Resi 28d. Describe		6 ☐Other (Speciary occurred	cify)	
	tal or Atter	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of	injury - At home, fa etc. <i>(Specify)</i>	arm, stre	eet, factory, office			28f. Location ( City or To	Street a wn, Sta	and Number or Ru ite)	ıral Route Number,	_
	he Hospi n 24 hour he Funer bletely fill	Medical (	29a. Certifier (Check only one)  1 X Certifying Ph 2 Medical Exam	ysician: To the be niner: On the basis and manner	s of examination ar	e, death	occurred at the ti restigation, in my	me, date opinion, d	and place, death occurr	and due to the ed at the time,	cause( date a	(s) and manner as and place, and due	stated. to the cause(s)	
ì	To the within comp	M	29b. Signature and title of certifier	U. Sus	igh		29c. Licens D004	4733(				pate signed (Monti nuary 28		
	2		30. Name and address of person who	171				0.7	Doc 1	(11c N	(II) 0	0052		
No.	Sta	te	Thomas Joseph, M.  31. Date filed (Marty Da) Gar/200	ע. סע wes	strar's Schature	yon	11., 11/2	0/,	KOCKV.	rite, M	ш Z	0034		_
	Registr	ar	#45 86 A		. 6	Mar.								

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State of Maryland / Dep State Registrar  State of Maryland / Dep	artment of Health and N ertificate of Death	ental Hygieı .Reg	_ < U U Ö	02102
	Physicia		Necedent's Name (First, Middle, Last)     KONSTANTINA MALAVAKIS		2. Date of Death Month JAN 23	Day Year	3. Time of Death 5:12 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  NATIONAL NAVAL MEDICAL CENTER	4b. City, Town, or Location of Death BETHESDA		4c. County of Death  MONTGOM	
	Funeral Director		5. Social Security Number 226−84−5261		8. Date of Birth (Month, Day, Ye Jan. 27,	9 Rirthnlag	ce (State or Foreign
4	D		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation			I. Inside City Limits
	r 28a-f sh	1 Y 1	Maryland Montgomery Bethesda  10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country	1 □ Yes 2 🔼 No y?
	3a o		7711 Arrowood Court	20817	Un	ited States	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mertal Hyglene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show if Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U.S. ' 13  Armed Forces?  1 □ Yes 2 ☒ No  If Yes Give	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Black, White, etc Specify: Wh	
21215-0036	in 72 hours "natural" Iedical Ex	Completed b	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)	king 16k	o. Kind of Business/Indu	stry
212	l within jiene.	E		ss Maker	Ga	arment Indu	stry
þ	e filed al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai	iden Surname)	
Maryland	should be filed vand Mental Hygie marked other tamatic event, the	ည	Athanasios Tzavaras		a Giokas	the as Town State 7in F	Paria)
Nar	2 sho n and I is ma rauma			ling Address (Street and Number or Ru			
as	1 and 2 Health tem 27 i		20b. Place of Disposition 20b. Place of Disp	1 Arrowood Court,		c. Location - City or Tow	
р	ages ent of t: If Its y or o		1 X Burial 2 Cremation 3 D Bemoval from State	ematory or other place) aven Cemetery Jan.	28, 2008 Si	lver Spring	, Maryland
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr		21. Signature of Funeral Service Licensee Ro	22 Name and Address of Facility une Obert A. Pumphrey Fune 557 Wisconsin Ave.	ral Home/Bet	hesda-Chevy Cl	nase, Inc.
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or healt failure. List only one cause on each line.			·, /	Approximate Intervat Between
	Physician /Medical		Immediate Cours (First	SEPSIS		(	Onset and Death
	Examiner						
	₽ / ≒	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
	and	xami	Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	dical Examiner	d				
9	tificate ig phy as the	Medic					
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Records,	e la has le 2	Completed			24a. Was an autopsy performe 1  Yes 2 <b>§</b>	prior to com death?	sy findings available pletion of cause of
Vital	sician; Th certificate rector, pag		25. Was case referred to medical	26. Place of De	ath (Check only one)		
Ξ	Physician; this certific ral director,	To Be	examiner? 1 ☐ Yes 2 ☐ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	ient 3 DOA Other: 4 Nursing h	Home 5 Residence	ce 6 ☐Other (Specify)	)
n 0	ng P fter t nera		27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury 28b. Time (Month, Day Year) Injury	y Work?	28d. Describe how	injury occurred	
Sio	Attending r death. ector: After oy the fune	catic	2 Accident investigation 3 Suicide 6 Could not be determined as a second not be determined not be determined as a second not be determined not be determined as a second not be determined not be determined as a second not be determined not be determined not be determined as a second not be determined not be dete	M 1 Yes 2 No	28f Location (Stre	et and Number or Rural	Route Number.
Division or	after d after d Direct d in by	Certification:	4 Homicide determined building, etc. (Specify)	street, lactory, office	City or Town,	State)	710410 714111401,
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director; A: completely filled in by the fu	Medical Co	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, de composition on the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occ	ce, and due to the cau curred at the time, dat	ise(s) and manner as state and place, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, E	
	/ - 0		Mu mo	0101237003 (	(VA)	JAN 24	2008
	5		30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print) NATIONAL NAV	AL MEDICAL		
			TARA M. WALKER LT MC USN	BETHESDA MD	20889-5600	0	
	St Regist	ate	31. Date filed (Month, Day, Year) 32. Reggran Signature	Spark			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 23 Year 3: 45 PM **Physician** January 2008 ANN MURRAY-YORKER /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A BALTIMORE CITY THE UNION MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, Year) 11/17/1963 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. WEST VIRGINIA 1 □ M 2 X F 216-92-7121 44 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No BALTIMORE CITY Director MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2641 MILES AVENUE 21211 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc 1 ☐ Never Married 2 X Married BLACK 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOUSEWIFE 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FLOREAN MONROE ARRIS ALLEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any Injury or other traum 2641 MILES AVENUE, BALTIMORE, MD 21211 PHILLIP YORKER / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/01/08 CATONSVILLE, MD METRO CREMATORY 4 Donation 5 Dother (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service Licensee 4600 LIBERTY HEIGHTS AVENUE, BALTIMORE, MD Enter the disease, or complications that caused the death, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate use (Final disease of condition Brain days Physician Anoxic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pog ycemic Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed Diabetes attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.0. 9 I Inknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed page certificate 212 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Tyes 2 No 2 ER/Outpatient 3 DOA 2 this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jagodee

Year)

JAN 29

M.D

ha

32. Registrar's Signature

29c. License number

AT2438946

Union Memorial

29d. Date signed (Month, Day, Year)

23,2008

January

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** Month ROSE MURRAY JAN. 21, 8:50A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GLEN BURNIE HEALTH CENTER GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 6/01/1934 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 73 MARYLAND 218-28-5990 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other thaumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at MD 1 XYes 2 ☐ No Director N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4708 SPRINGDALE AVENUE 21207 USA Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify: BLACK Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry  $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12TH \end{array}$ College (1-4or 5+) CASHIER RETAIL 17. Father's Name (*First, Middle, Last*) UNK 18. Mother's Name (First, Middle, Maiden Surname) Be HILDRA HUTCHINSON ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES MURRAY / BROTHER 4708 SPRINGDALE AVENUE, BALTIMORE, MD 21207 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State METRO CREMATORY 01/24/08 CATONSVILLE, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD e, or complications that, aused the death List only one cause on each line. Immedi fe use (Final disease condition resulting in death) Physician /Medical or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transi certificate be exec Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year signed by the a d be detached for 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform certificate 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 4 Unursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🗌 Yes 2 No 2 Accident

Box 68760, P.O. Division or Vital Records, or Attending

nours after death.

neral Director; After the filled in by the funeral

within 24 hours a To the Funeral I

Medical

To the Hospital

State Registrar 29b. Signature and title of certifier

and manner stated

Registrar's Signature

6 ☐ Could not be

determined

3 ☐ Suicide

29a, Certifier

4 ☐ Homicide

31. Date filed (Month, Day, Year)

29c. License number D23530

1 Procertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TENJEG TSHOL

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

08-00657
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	s iia ivicca		1- For State Registrar	tate of Maryla	•	ificate o			Rec	j. No. 21	08 0210
Vledi	Physici cal Exami		Decedent's Name (First, Midd     James In		cCanns	Jr			2. Date of Death Month January 23		3. Time of Death 1424 hrs
. لدي			4a. Facility Name (if not institution					r Location of Dea		4c. County of De	
			10303 Sunnylake Pla		·		Cockeysvil	le		Baltimore C	county
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Ye			(MM/DD/YYYY) 9.	Birthplace (State or reign
	Director	2	218-86-5717	1 M 2 F	37	Yrs	Months Day	ys Hours Mi	Nov. 2	27,1970	Country) MD
	any		Usual Residence of Decedent  10a. State 10b. County		10d. Inside City Limits						
		L	MD Balti	more		ockeys					1 Yes 2 X No
1	arylar 8a-f s at on	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What C	Country?
0	paritified E, MID 21219-0030 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Dir	10303 Sunnylak	e Place A	pt.D		21030			U.S.A.	
1/2	th with ems 2. t be n	Funeral	11. Marital Status 1 X Never Married 2 N	12. Was Dec	edent Ever in U.S			ispanic Origin? (	Specify Yes or No- to Rican, etc.)	14. Race - Ar White, et	merican Indian, Black,
-	er dea' , or it			1 Yes	2 X No		Yes 2 X N		. ,	Specify: V	Vhite
	urs aft tural" amine	d by	15. Decedent's Education (Spe	or Dates:				ation (Give kind o	f work done	16b. Kind of Busine	
	72 hoi n "na sal Ex	Completed by	Elementary/Secondary (0-12)			during m	nost of working life	e. DO NOT use re	etired)		
7600	within ene. er tha	mp	10			Inspe	ction			Build	ing
n Z	filed v I Hygi ed oth		17. Father's Name (First, Middle James I. McCan						ne (First, Middle, M Ann Azza:	•	
5	LIL	To Be	19a. Informant's Name/Relations			19b. Mailin	g Address (Stre	A STATE OF THE STA		La ber, City or Town, S	tate, Zip Code)
5	2 sho 2 sho h and 27 is		Mrs. Nancy McC	anns/Moth	er						MD 21060
-	Healt Fitem		20a. Method of Disposition  1 X Burial 2 Crematio		20b. Pi		sition (Name of co	emetery, Ja	an. 28,	20c. Location - Cit	
8	Pages nent of		4 Donation 5 Other S		om state	•	emer Cen		2008	Baltimor	e, MD
3	Dalli permit. Departn Imports injury o		21, Signature of Funeral Service	Licensee	/						Cremation
			23a. Part   Enter the disease, o	Van-	Mo/3						Le, MD 21061 Approximate Interval
t	Physician /Medical		failure List only one cause	e on each line.						St, Shock, or fleart	Between Onset and Death
	caminer		Immediate Cause (Final disease or condition resulting in death)		nsive athe		otic cardi	iovascular	disease		Dodin
			Sequentially list conditions,	b							
		iner	if any, leading to immediate cause. Enter Underlying Cause		consequence of)	i.					
	- ·i	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of)						
	recuted and trans	alE		d							
9	e be es	Medical	X UNPENDED	#23a,PI	I.27.perMF	.g876.	2/20/08 TI				
276	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	M/u	IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	230. II yes,	outcome of pregni	aricy	etal death 3	Ectopic preg	nancy	23d. Date of del Month	Day Year
20 cg	ath cer attendi	Physician/		line and	ant at time of dea	th	ther (Specify)				
	t the dea	Phy	Part II. Other significant condi	9 Ulikhi		culting in the	underlying cause	given in Part I	23e Did to	hacco use contribut	e to the cause of death?
	res that the d signed by the	by	Chronic alc		death but not res	sularing in the	underlying cause	given in Fait i.	1 Yes		Probably 4 V Unknown
Division of Wital Bosonde	law require	Completed		0.10.22.2					24a. Was a		e autopsy findings available
Ş	e law i e has t	g E	<del></del>						_ autops perfor	med? deat	
۵	ician: The lician: The lician: The lician: The licians are rector, page		25. Was case referred to medica	al			26.Plac	ce of Death (Chec	1 Yes 2	2 No 1 🗸	Yes 2 No
/its	hysicia this cer il direct	To Be	examiner?	Lippoital: CO	npatient 2 E	ER/Outpatien		Other:		Residence 6 🗸 0	Other: Scene
ų.	After t	<u> </u>	27. Manner of Death	28a. Date (Month	of Injury , Day, Year)	28b. Time of	Injury 28c. Inj	ury at Work?	28d. Describe h	low injury occurred	
	ttendi death. tor: ,	aţi		ding estigation			1	Yes 2 No			
į	pital or At ours after d eral Direct filled in by	Certification:	3 Suicide 6 Cou	ild not be 28e. Plac	e of Injury - At hor	me, farm, stre	et, factory, office	building, etc.	28f. Location (S or Town, St		r Rural Route Number, City
	ospita hours imeral		4 Homicide	(opeciny)				d-4 d 1	1	. (-)	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only   Certifying F	hysician: To the bes aminer:On the basis	of examination an						
	To wit	Mec	29b. Signature and title of certifi	and manner s	tated.		29c. Licer	nse number		29d. Date signed	(Month, Day, Year)
	0		Alimen 1	11-16	TN		0.0	.M.E. 00	ME	January 24, 2	800
			30. Name and address of person								
1			Theodore M. King, Jr	1	nt Medical Ex		111 Penn S	treet, Baltimo	ore, MD 21201		
	Si	tate	31. Date filed (Month, Day, Year)	2008 32	gístrar's Signatur	e	M -				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 6.40 PM YASMIN MORTON JANUARY /Medical 23 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 5. Social Security Number 100 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 9. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 6. Sex **Funeral** 1□M 2 F 789 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f shov idical Examiner must be notified at MD andalistown 1 ☐ Yes 2 No Director Himore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2113 800 Plowline Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) ss 1 and 2 should be filed within Health and Mental Hygiene. College (1-4or 5+) Baltimore 13 years 5+years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PerKins David eales 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rd. Randellston, MD 21133 9805 Morton Plowline Husband Bemard 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☑ Burial 2 □ Cremation 3 □ Removal from State Harrison For 08 DWINGS Mills, IND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vayanc. Greene tuneral Sites 21. Signature of Funeral Service Licensee 8 101401 7286 -iberty Rd. Francialestin, 110 Zi133 and. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death modiate Cause (Final **Physician** TASTATI REAST ease or condition resulting in death) E /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, leave. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ar as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes been signed by the a should be detached f 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 No To the Hospital or Attending Physician; completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) s after death. 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) LE DAKIS MO 25,2008 JANUARY 7034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
P. LENATR'S M. 227 ST. PAUL PLACE UENATUS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 29 2008 DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 25 Month Year **Physician** McDonald William Bell COULD M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Buttimare VA medical center Battimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Days 213-30-4017 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified of 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore 1 ☐Yes 2 HNO MD Pikesville Director 10e. Street and Number 10g. Citizen of What Country? 21208 3730 Par Kfield by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ∏ Yes 2 □ If Yes, Give Year or Dates: 2 🗌 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Black 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hers LongShoreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William MEDonald SR Williams Janie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) [Niece] Pikesville, MD. 21208 Parkfield Rd. Seanette 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 29/08 Greenmount Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licensee 22. Name and Address of Facility Lemation Services Balti. MD. 21229 Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Understand Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) use as the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by bementia, copo, Diabetes, Postate cancer. 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No N/O Newsyphillis : Chronic Kidny 24a. Was an performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Mijpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation

Division or Vital Records, P.O. Box 68760, Director:

Certification: To Be 1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

6 ☐ Could not be

determined

Medical Resident

AU4176435718183

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address person who completed cause of death (Item 23a) (Type, Print) Minghan Les Tsay 13 N. Greene

32. Raistrar's Signature

street, Baltimore,

Neas

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 26, JANUARY 2008 10:10 PM **EMMA** NEAL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 26,1920 6. Sex 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 213-14-3994 87 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1005 Regina Drive 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 2 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death ,2008 **Physician** Month January 28 Zoe Parrott /Medical Μ. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner OWN IVZNO tim ore Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months 1□M 2XF Davs Hours Min. 217-48-6303 96 Director May 25, 1911 Indiana Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show notified at show 10d. Inside City Limits Director MD 1 ∐Yes 2 No Baltimore Catonsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 709 Maiden Choice Lane 21228 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 XYes 2 □ No If Yes, Give Year or Dates: WW II 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home injury or other traumatic event. 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Hugh McFadden Lucy Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trau Thomas M. Parrott / son 39 Edmondson Ridge Road Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 **X** Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (*Specify*) 3 □ Removal from State Metro Crematory, Inc. 01/28/08 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of MD, Inc. George MacNabb 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one or use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** amen ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 1 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Hursing Home 5 Residence 6 Other (Specify) 2 Hospital: 1 ☐ Yes ပ 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 1 ☐ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident death the Funeral Director; filled in by the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Att within 24 hours after days to the Funeral Direct determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d, Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) laiden hoice

Registrar

State

n, Day, Year)

29

2008

🕊. Registrar's Signature

JANUARY 23, 2008 3:00 a.m. Baltimore, Maryland 21215-0036

JACLYN PASCARELLA Division or Vital Records, P.O. Box 68760, と

			Please				Indelible Ink.				gible.	
		For		State of M	arylan		epartment of H			1	008	02111
		State     Registrar  1. Decedent's Name	Eiret Middle	( ast)			Certificate of I	Deam	2. Date of Dea	Reg. No. S⊶ ath		3. Time of Death
Physicia	n	1. Decedent s Name		N CHRISTINE	WALS	SH PA	ASCARELLA		Month January	Day 23, 2	Year 2008	3:00 A M
/Medica Examine	-	4a. Facility Name (If	f not institution, g	give street and number)			4b. City, Town, o	r Location of Death	Journal		inty of Dea	
	8		MARIS HO		(1	la a t bieth	Timon	ium   If Under 24 Hrs.	8. Date of Birt			e County thplace (State or Foreign
Funeral Director		5. Social Security No. 538–50–40		. Sex 7. Aq 1 ☐ M 2 🂢 F	ge <i>(In yrs.</i> 1		Months Days	Hours Min.	Nov 14	y, Year)	C	hington
and	-	Usual Residence of	Decedent						1100 14	, 1,740	was	10d. Inside City Limits
arylan show d at	.	10a. State	10b. County				or Location					1 ☑ Yes 2 ☐ No
the Ma 28a-f	S 1	Mary Land		Georges Co		CoT	lege Park			10g. Citizen	of What C	ountry?
3a or				ester Park	Drive	e, #.		0740		Į	USA	
death	Funeral	11. Marital Status		12. Was Decedent Armed Forces	Ever in U.	S.	13. Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Amo Black, Whi	erican Indian, te, etc.
s after	by Fu	1 Never Marri			No OLV		1 ☐ Yes 2 💆 No			1	ecify:	White
tural	ed b		15. Decedent's	Education		16a. [	Decedent's Usual Occup	pation		16b. Kind o	of Business	/Industry
hin 72 e. an "na Medic	Completed	(Speci		grade completed)  College (1-4or	5+)	I .	Give kind of work done life. DO NOT use retired		ang	M. 11	1 10	1.
ed will lygien her th	ទី	AT Full of Name	(First Middle I.	2 yrs		<u> </u>	ab Technici	.an 18. Mother's Nam	e (First Middle			esearch
d be filed that he ed out	Be	17. Father's Name	enry Wal						Jean Br		,	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	은	19a. Informant's Na				19b.	Mailing Address (Street				wn, State,	Zip Code)
and 2 salth a n 27 is er tra		Joanne P	. Watson	n (Daughte			7 E. Burke			Maryla		
ges 1 t of He If iten or oth		20a. Method of Disp 1 Burial 2		B ☐Removal from State	3		Disposition (Name of crematory or other pla		Date		-	r Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	-	-	5 Other (Spe	conten	Gre	een l	Mount Crema		+/2008	Baltin	nore,	Maryland
perm Depa Impo any i		Mar	un vy	awson			MITCHELL- 6500 York	WIEDEFELI Road Ba	) FUNERA	L HOM	E, IN	C. 21212
F &		23a. Part1. Enter t	the disease, or c art failure. List o	omplications that cause nly one cause on each	ed the deat line.	h. Do n	ot enter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	23203	Approximate Interval Between Onset and Death
Physician		Immediate Cause disease or condition	(Final	LIVER		R						Onset and Dead
/Medical Examiner		resulting in death)	1	Due to (or a	s a conseq	uence o	f):					
	Je.	Sequentially list co if any, leading to in	onditions, nmediate	b. Due to (or a	s a conseq	uence o	f):					
executed n and ial-transit	Examiner	Cause (Disease or that initiated events	r injury s	c								
- 00 -		resulting in death)	Last	Due to (or a	s a consec	luence o	т):					
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	Physician/Medical			d								
h certi	July M	IF FEMALE: 23b. Was deceder		23c. If yes, outcom			3 ☐Ectopic pregnanc	CV CV		23d	Date of d	elivery Day Year
e deat the attu	sicis	in the past 12 1 ☐ Yes 2】 9 ☐ Unknowr	No	4□Pregnant 9□Unknown			5 Other (specify)				MOITH	Day Teal
that the	Phy			ns contributing to death	but not res	sulting in	the underlying cause gi	ven in Part I.	23e. Did	tobacco use	contribute	to the cause of death?
quires	d by								1 🗆	Yes 2□1	Vo 3□I	Probably 4 LUnknown
law rec as bee 2 shou	plete								24a. Was		prior to	autopsy findings available completion of cause of
(O ===	Completed								perfe 1□ Yes	ormed? 2 <b>▼</b> No	death1 1 ☐ Ye	_
Attending Physician: Threath. rdeath. ector: After this certificate by the funeral director, pag	Be	25. Was case refe examiner?	_	Hospital:	tiont 2	3 EP/Out	patient 3 DOA Ot	26. Place of Dea			Other (Se	HOCDICE
Phys er this eral dii	T0	1 ☐ Yes 2 X 27. Manner of Dea	ıth	1 ☐ Inpa 28a. Date of Ir	ijury	28b. T	ime of 28c. Inju	4 Li Nursing H	28d. Describe			ecify) HOSPICE
ath. nr: Afte	atior	1 X Natural 2 ☐ Accident	5 Pending investiga	ation	ay rear)			Yes 2 No				
or Atter frer de Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	200. Flace of I	njury - At h etc. <i>(Speci</i>		rm, street, factory, office		28f. Location ( City or To	(Street and Nown, State)	lumber or i	Rural Route Number,
e Hospital or Attending R 24 hours after death. e Funeral Director: After etely filled in by the funer		29a. Certifier	1 X Certifying	Physician: To the bes	st of my kn	owledge	, death occurred at the	time, date and place	e, and due to the	e cause(s) ar	nd manner	as stated.
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only one)	2 Medical E	Examiner: On the basis and manner	of examin	ation an	d/or investigation, in my	opinion, death occi	urred at the time	, date and pi	ace, and d	ue to the cause(s)
To the I within 2. To the I complet	Ž	29b. Signature and	d title of certifier				29c. Licen	ise number	_			nth, Day, Year)
6		20 Name and a little	drace of posses	who completed cause of	f death /Ito	m 23a) /	Tyne, Print)	13725			2	
12			RIO MAHM	100D 2300a	DULAN	EY V	ALLEY RD.	TIMONIUM	, MD 210	093		
Sta		31. Date filed (Mod	nth. Dav. Year)	32. <b>E</b> gi	strar's Sign	nature	frest.		-			
Registr	ar		JAN 23	7 7000	2000	-	9 8					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1725/08ay **Physician** 6:30 P M LARRY PEAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA Baltimore 5911 Radecke Ave Apt F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex-1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 56 MD 2/5/51 212-56-9765 **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1√2 Yes 2 □ No Director Baltimore NA MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A 21206 Funeral 5911 Radecke Ave Apt F death 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. int: If Item 27 Is marked other than "natural", or Ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Environmental Service 10th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic ev Peav Fannie McCullough Aaron 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Baltimore, MD 21206 5911 Radecke Ave Apt F Delores Jackson-Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/30/08 Randallstown,MD Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marcheast PH East North Ave Baltimore, MD 21202 1101 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ONE YEAR ANCREATIL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 1 ☐ Yes 2 No 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy perform prior to complete death? 1 ☐ Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral s after death. 27. Marner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 29a. Certifier 1 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar LUIS DIAZ

31. Date filed (Month, Day, Year) 32, Regis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32, Registrar's Signature

32 Hegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 23 20'08 12:35P <sup>™</sup> Barbara I. Parrish January 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Washington Medical Center Glen Burnie Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number Months Days Hours Min. 1 □ M 2 F 235-60-9058 Sept. 21,1939 68 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 ◯XNo MD Anne Arundel Severn 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 1433 Virginia Avenue 21144 U.S.A. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 💆 No White Specify. Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Store Manager Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond C. Legg Mavis Riggles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Virgil Parrish/Husband 1433 Virginia Avenue Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 28. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 2008 Brooklyn Park, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Singleton Funeral & Cremation selemo 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? nditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 KNo 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3 DOA 1 ∐ Yes 2 ∐ntNo 1 Inpatient 2 ER/Outpatient 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

**Examiner** be executed burial-tran Division or Vital Records, P.O. Box 68760 physician the attending p for use as as ed by the a signed by has page 2 certificate this funeral After t Hospital or Attending death. within 24 hours after death To the Funeral Director:

**Physician** 

/Medical

Examiner

Director

Funeral

Be Completed by

**Funeral** 

Director

other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at

death with the Maryland

filed within 72 hours after

1 and 2 should

Pages ' Department of I

is marked oth be

other traumatic

: If item

**Physician** /Medical

Examiner

Physician/Medical

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Completed

Be

P

Certification:

Medical

filled in by

Maryland

altimore,

IF FEMALE:  23b. Was decedent pregnan in the past 12 months?  1 ☐ Yes 2 ☑ No
9 ☐ Unknown \
Part II. Other significant con

29a. Certifier

3 Suicide

4 Homicide

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

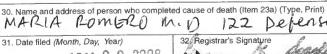
28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

31. Date filed (Month, Day, Year)

29 2008

6 ☐ Could not be



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 PAUNB Oi WINSTON ASHANTE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SILVER SILVER STITUS

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, SPRING CROSS HOSPITAL MONTGOMERY Birthplace (State or Foreign Country) 6. Sex / 1 M M 2 ☐ F 5. Social Security Number 7. Age (In yrs, last birthday) Hours 13 **Funeral** MARYLAND Director NONE Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eeith and Mental Hygiene.
n 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 Ves 2 No Director PG COUNTY ADELPHI 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2078 9274 ADELPH SA Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: BLACK Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-46r 5+) Elementary/Secondary (0-12) INPANT INFANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be IDAMA PAUNE SARAH 204 WCLEOD ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1500 POREST GLEN RD SILVER SPRING MD 1090 HOLY CROSS HOSPITAL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state 21. Signature of Euneral Septice Licensee Wades Director 22. Name and Address of Facility Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HUPOPLASTIC Immediate Sause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner 1045510 MULT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certification: To Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2 No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending ours after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier BOOK 18 and address of person who completed cause of death (Item 23a) (Type, Print) OIPOR AM DUISAS STAND BY MED TERROT OCTI. OM MINO JANE

State

Registrar

31. Date filed (Month, Day, Year)

2 9 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:05A <sup>M</sup> January 28, 2008 GENEVIEVE AGNES QUIGLEY ROSENTHAL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** STELLA MARIS HOSPICE Baltimore County Timonium 8. Date of Birth (Month, Day, Year)
Aug 25, 19 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗓 F Yrs. Maryland 78 1929 Director 217-26-0847 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Funeral Director Maryland Baltimore County Timonium 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21093 USA 7 Kilcolman Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No White Specify: Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specity only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Self Employed Restaurant 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Joseph Quigley Jeanette Logue ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Kilcolman Court, Timonium, Maryland 21093
ce of Disposition (Name of Date 20c. Location - City or Town, S <u> Sharon A. Bielajew (Daughter)</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ∑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Grdns 1/31/2008 Timonium, Maryland 21. Signatur for Funger Service Denses 22 Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final adenocaranoma - unknown primney **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performe Division or Vital 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NOS PICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Natural 2 ☐ Accident after death 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Underlined the time, date and place, and due to the cause(s) and manner as stated. (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 Dulancy Valley Rd. Timonium, Md 21093 2300 Tariq Mamood, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 04:00 AM John T. Robinson 2008 Danuary /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** n/a Baltimore, Maryland
If Under 1 Year | If Under 24 Hrs. | 8. Date 9 ST. Agnes Hospita

5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 8/21/1928 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1XM 2□ F 79 220-20-4130 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. Counfy 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No n/a Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1442 William Street 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛭 No White Baltimore, Maryland 21215-0036 Specify: þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) Professor State University 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James H. Robinson, Sr. Nora FLynn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: if Item 27 I any injury or other tra Claire Robinson / Dau. 1442 William Street, Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 1/31/2008 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Proumonia 3-4 days **Physician** /Medical Due to (or as a consequence of): Examiner PRINCIPY Tract Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-trar Due to (or as a consequence of) Physician/Medical the attending properties for use as 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? res 2 No certificate Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 No 1 🗌 Yes 2 ER/Outpatient 3 DOA P 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: Hospital or Attending 124 hours after death. 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 28 ,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland 21229 Caton Itimore, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 11 11 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Darcella Ann Rothe 7:45 рм 2008 27 Jan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 1112 Sunnybrook Drive Glen Burnie If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, Social Security Number **Funeral** 1 □ M 2 🔀 F 1956 Maryland 51 Sept 24, 214-62-6278 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County rai", or Items 23a or 28a-f show Examiner must be notified at Glen Burnie 1 ☐ Yes 2X No Maryland Anne Arundel the I 10g. Citizen of What Country? 10e. Street and Number 1112 Sunnybrook Drive 10f. Zip Code 21060 United States Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications 12 Payroll 7 is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Betty Grewe Conda Lewis ပ္ permit. Pages 1 and 2 shoul Department of Health and Mu Important: If item 27 Is mark any Injury or other traumati once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William C. Rothe, Sr. Husband 1112 Sunnybrook Drive, Glen Burnie, Maryland 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Marriottsville, MD 1/31/08 Crest Lawn Mem. Gdn. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee Mark T. 4107 Wilkens Avenue, Baltimore, Maryland 21229 e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final 3 months Physician non-small disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed Yes 2 has certificate 1∐ Yes the Hospital or Attending Physician: r this certificaral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 □Other (Specify, 2 ER/Outpatient 3□ DOA 1 Inpatient ပ္ 1 Tyes 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Vithin 24 hours are:

To the Funeral Dir Cedifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and titl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ь 22 South Greene St Martin Edelman Baltmere, MD M.D 32. Regiştrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month,

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	Examin	er	Broadmead				Cock	eysvil	.1e		Baltimo	re
	Funeral		5. Social Security Number 6.		7. Age (In yrs.	. last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8 Da	te of Birth onth, Day, Y	(ear) 9. Bir	thplace (State or Foreign
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Maryland 21215-0036	Mer Marke	_C	Thomas Warden Ri			10h Mailie	ng Address (Street a		Grime		ity or Town State	Zin Code)
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e,	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "netural", or Items 23e or 28a-1 ehow or other traumatic event, Ite Medical Examiner must be notified at		Gail Rinehart/wif	.e	20b.	Place of Dispo	sition (Name of		Date		c. Location - City or	
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Ba	permit. Pages 1 and 2 s Department of Health ar Importent: if Item 27 is any injury or other trau ODC®.		Michael J.	Flagle		1	Lemmon Fu O W. Pado	nera <u>l</u> nia Rd	Home C	of Dul	aney Vall	ley, Inc.
			23a. Part1. Enter the disease, or cor	nolications that ca	used the dea							Approximate Interval Between
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8760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dlcal	•	d								
9 ×	ding page as	/Me	IF FEMALE:	23c. If yes, outo	come of preor	nancy					23d. Date of de	divery
Вох	atten for us	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi	nth 2 ☐ Fet	tal death 3	Ectopic pregnancy Other (specify)				Month	Day Year
o.	The law requires that the death certificate has been signed by the attending prage 2 should be detached for use as	by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno		404						
₾.	that led by deta	y Ph	Part II. Other significant conditions	contributing to de	ath but not re	sulting in the u	nderlying cause give	n in Part I.	2	3e. Did toba	cco use contribute	to the cause of death?
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00	w req	Completed							2	4a. Was an	24b. Were a	utopsy findings available completion of cause of
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0	ng Ph ter th neral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date o (Monti	f Injury h, Day Year)	28b. Time o	f 28c. Injury Work	at ?	28d. D	escribe how	injury occurred	
<u>0</u>	or Attending I after death. Director: After in by the funer	atic	2 Accident investigati	1			M 1 🗆 Y	'es 2□No				
Division of	er de	ij	3 ☐ Suicide 6 ☐ Could not determine	d 28e. Place	of Injury - At I ig, etc. (Spec	home, farm, str cify)	reet, factory, office		28f. Lc	ity or Town,	et and Number or F State)	Rural Route Number,
	5 F F C	- I										
	urs after arel Dire	Certification:	SON Comition		hant of my ke	audadaa daat	h accurred at the tim	o data and i	place and du	in to the cau	see(s) and manner s	is stated
	Hospital or 24 hours aft Funerel Di		29a. Certifier 1 Certifying F (Check only one) 2 Medical Ext	Physician: To the	sis of examin	nowledge, deat nation and/or in	h occurred at the tim vestigation, in my op	e, date and pinion, death	place, and du occurred at t	ie to the cau he time, dat	ise(s) and manner a e and place, and du	is stated. le to the cause(s)
	o the Hospital or ithin 24 hours aft o the Funerel Di ompletely filled in	Medical Cer	(Check only 2 Medical Ext	Physician: To the	sis of examin	nowledge, deat nation and/or in	h occurred at the tim evestigation, in my op	inion, death	place, and du occurred at t	he time, dat	ise(s) and manner a e and place, and du d. Date signed (Mor	e to the cause(s)
)	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funerel Director; After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical Exa	Physician: To the	sis of examin	nowledge, deat nation and/or in	vestigation, in my op	inion, death	place, and du occurred at t	he time, dat	e and place, and du	e to the cause(s)
ļ		edical	(Check only 2 Medical Extraore)  29b. Signature and title of certifier	Physician: To the	sis of examiner stated.	Mation and/or in	vestigation, in my op	inion, death	place, and du occurred at t	he time, dat	e and place, and du	e to the cause(s)
ŀ	To the Hospital or within 24 hours aft To the Funerel Di completely filled in	edical	(Check only 2 Medical Extraore)  29b. Signature and title of certifier	Physician: To the particle of the barring and mann	sis of examiner stated.	Mation and/or in	vestigation, in my op	inion, death	place, and du occurred at t	he time, dat	e and place, and du	e to the cause(s)
		Medical	(Check only 2 Medical Extrapole)  29b. Signature and title of certifier  30. Name and address of person who BAR BARA  31. Date filed (Month, Day, Year)	Physician: To the saminer: On the baland mann of th	sis of examiner stated.	anation and/or in	vestigation, in my op	inion, death	place, and du occurred at t	he time, dat	e and place, and du	e to the cause(s)

DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:30 A 2008 Jan Frank C. Rawlings /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** George's Clinton Nursing Center Clinton Prince Birthplece (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 6. Sex 5. Social Security Number 1□M 2□F **Funeral** Washington D.C 69 Aug 17, 1938 218 34 7328 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b County or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Prince George's Clinton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9211 Stuart Lane 20735 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [TYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or ite eny injury or other traumatic event, the Medical Examina 2008. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ NO Be Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction 9 0 Carpenter 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Mary Ellen Hayes ၉ Frank Caleb Rawlings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3507 56th Street, Landover Hills, MD 20784
Date | 20c. Location - City or Town, State Julia Jones (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Feb. 4,2008 Cheltenham, MD Maryland Veterans 4 □ Donation 5 □ Other (Specify) 21. Signature of Puneral Service Lig 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 04 23a. Pert1. Ento the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heer trillyre. List only one cause on each line.

Immediate cause (Final disease or condition resulting in death)

a. AThere solers to Condition resulting in death) Alexandria Ferry Road, Clinton, MD 20735 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Apua or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2₽No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check on one Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To this filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) After 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 - Homicide within 24 hours a To the Funerel C Hospitel 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 01-23-0% 045365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Sidarous, M.D. 1170 Livingston Road #101, Fort Washington, MD 20744 31. Date filed (Month, Day, Year) 32. Registrar's Signature, State (1338) JAN 2 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** James R. Randall 01-28-2008 1:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Madonna Hertiage Harford Jarrettsville If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 187 M 2□ F 219-03-3708 Yrs. Maryland Director 87 09-02-1920 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show "nature!, or iteme 23e or 28a-f show 1 ☐ Yes 2 No Harford Maryland Bel Air Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 D. Canterbury Rd 21014 U.S.A. Funerai deeth 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 万 Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry IDS Ms Elementary/Secondary (0-12) College (1-4or 5+) 12 Self Employed Vending Company 7 le marked other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Louis A. Randall Martha Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a litem 27 li Hannah L. Randall (Wife) 304 D. Canterbury Rd BelAir, MD 21014 Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Depertment of Importent: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 02-01-2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Demenha /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-translt Due to (or as a consequence of): Box 68760, attending physicien for use as the buria leted by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ned by the a o 9 Unknown 9 Unknown ۵. signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown COPD should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s CAD autopsy performed? farling Rend Chimi 1 Yes 2 No 1 Tyes 2□ No of Vital or Attending Physicien: director Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSIS/ad Liu 1 Yes 2 No Certification: To After thi 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1: Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funarel Director: A completely filled in by the fu investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Medicai 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Winds

31. Date filed Month Pay, Yarn

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32 Registrar's Signature

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1/28/08

21200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5.00 PM William Walter Robey Sr. AMUARY 24 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner N BURNIE MEDICAL CA AMNE NIER ELLNISEL MOTIPHILLANDI. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days 215-12-0523 85 Dec.11,1922 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hyglent. Depertment of Health and Mental Hyglent in Part 18 marked other than "natural", or items 23a or 28a-f show Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Severn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 857 Cork Elm Court 21144 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black White etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 □ Yes 2X No Specify Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Jefferson Robey Sr. Anna Eleanor Darnall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Beatrice A. Robey/Wife 857 Cork Elm Court Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition Jan. 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem. 2008 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee MO1357 Services 1 2nd Avenue Glen Burnie, MD 21061 23a. Part1. Edite the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached fo 1 ☐ Yes 2 ☐ No. Ö 9 Unknown σ. The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 3 ☐ Probably 4 ☑ Unknown 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an ate has l page 2 s 2 No certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral. 27. Man r of Death 1 √ atural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di 1 «Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Drive

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 0955 Keed Vancary 2008 10010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bathrose aty N/A The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** 1□ M 2□ F APR.10.1921 S.C 215 24 5699 86 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at MD. N/A BALTIMORE X□Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 240 DOUGLAS COURT 21231 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status nit. Pages 1 and 2 should be filed within 72 hours after artment of Health and Mental Hygiene.

ortant: If item 27 Is marked other than "natural", or Ite injury or other traumatic event, the Medical Examine 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√ No Specify Specify: BLACK þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 CUSTODIAN BALTIMORE CITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PEARSON RANDOLPH HETTIE GARRETT ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LARRY RICHARDSON(son) 4852 CLAYBURY AVE. BALTO, MD. 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition cemetery, crematory or other place)

GARRISON FOREST VETERAN 1⊠ Burial 2 ☐ Cremation 3 Removal from State permit. Page Department o Important: If any injury or 4 Donation 5 ☐ Other (Specify) CEM OWINGS MILLS, MD. Signature of Funeral Service Licensee 22 Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME PRESTON ST. BALTO MD 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) postoboniche preumonia **Physician** 4days /Medical Due to (or as a consequence of): Examiner b. UNIVOTACIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine tobacco abusc and Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 2 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 ☐ Yes 2 ☑ No performed Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 ☐ Yes 20 No 2 ER/Outpatient 3 DOA Certification: To ision or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident hours after death uneral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

1 State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

Reg-000

thlang Thoma, The June Hopting Horpital, 600 Northwolfe givet, Balthrore, Many land, 21207

29d. Date signed (Month, Day, Year)

20,2000

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and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

> Medical doctor

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylan	d / Depa <i>Cer</i>	artment of H	ealth and N Death		giene (	008	02124
			Registrar  1. Decedent's Name (First, Middle,	Last)					2. Date of Dea	ith		3. Time of Death
	Physicia		Dolores J. Red						Month January	19. 2	.008	11:25 PM
	/Medic Examin		4a. Facility Name (If not institution,		umber)		4b. City, Town, or	Location of Death			nty of Death	
	Examin	er	Pickersgill Re				Towson	n		Ba1	e	
	Eunaral			S. Sex	7. Age (In yrs.	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Your	9. Birth	place (State or Foreign
	Funeral Director		217-14-3002	1 ☐ M 2 📆 F	86	Yrs.	Months Days	Hours Min.	Jan 1,	1922	Mary	yland
			Usual Residence of Decedent									
	nylan how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	a-fs	cto	MD Balti	nore	I	owson						1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen		ntry?
	be filed within 72 hours after death with the Maryland lat Hyglene of other than "netural", or items 23a or 28a-f show event, I'm Modical Examiner must be notified at	ai	615 Chestnut A	venue				1204			USA	
	ems erms	Completed by Funeral	11. Marital Status	Armed F		S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. F	Race - Ameri Black, White,	
õ	or It	Y.F.	1 Never Married 2 Marrie	If Yes, G			1 ☐ Yes 2 💢 No	Specify:		Spe	city: Wh	nite
Š	ural',	q p	3 Widowed 4 □ Divorced	Year or	Dates:	10.0	dent's Usual Occupa			10h Kind of	Business/In	adustar
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N	filed wit Hygien other the	ပိ	12 17. Father's Name (First, Middle, L	ast)	U	CIE	:LICal	18. Mother's Nam	ne (First, Middle,			
ă	e d fa	Be	Francis Martin					Margaret	Joseph	ine Ki	ng	
Ž	d Me	ို	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street a					p Code)
Maryland 21215-0036	d 2 sho		Tate Redding/s				Boyce Ave			21204		
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		20a. Method of Disposition		20b. F		sition (Name of natory or other place		Date	20c. Locatio	on - City or T	own, State
פֿ	Pages nent of int: If it iry or o		1 Burial 2 Cremation		n State	emetery, crer	natory or other plac	(a)				
altimore,	rtant rtant	l i	* 4 ☑ Donation 5 ☐ Other (Sp		6	-22	Name and Addres	ss of Facility	1 (55 11	D 1.1		O h
Ba	permit. Pages Department of It Important: If Ite any injury or of		21. Signature of Euneral Struce ROT 3 LV	Wade	Director	r Si	Name and Address	omy Board	d 655 W.	Balti	Lmore	Street
	19.2		23a. Part 1. Inter the disease, or a shock, or heart failure. List of the control	omplications that	caused the deat	h. Do not ent	altimore, er the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate
			shock, or heart failure. List of	nly one cause on	each line.	i	Der	no ti	1			Interval Between Onset and Death
1900	Physician /Medical		disease or condition resulting in death)	a/			yer	100/0 (11			-	Jenera
	Examiner			Due to	o (or as a conseq	uence ot):					16	
		-	Sequentially list conditions,	b. Due to	o (or as a conseq	uence of):						
	ted nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
	al-tra	Examiner	that initiated events resulting in death) Last	c Due to	o (or as a conseq	uence of):						
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit			4								
89	ficate phy: s the	edicai		J								
×	that the death certifi ed by the attending detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		Te Toronto Control			23d.	Date of deliv	
Box	atter d for	ciai	in the past 12 months?	4□Pre	birth 2 ☐ Feta gnant at time of d		Ectopic pregnancy Other (specify)				Month	Day Year
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<u>ہ</u>	res that igned b be deta	Y P	Part II. Other significant condition	s contributing to	death but not res	ulting in the u	nderlying cause give	en in Part I.				the cause of death?
Sp	quire n sign								101	res 2√⊡No	3 ☐ Pro	bably 4 Unknown
ō	w require been sign should b	Completed							24a. Was	an 24	b. Were aut	opsy findings available
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ā	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical					26 Place of Dea	th (Check only o			
5	Physician: r this certificanal director,	0 13	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 Nursing H			Other (Spec	ify)
ō	Phys or this oral di	$\vdash$	27. Manner of Death	28a. Dat	e of Injury	28b. Time o			28d. Describe I			
o	th. : After s funer	텵	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig		onth, Day Year)	Injury	M 1 🗆	Yes 2 □No				
Division of	or Attending after death. Director: After in by the fune	Hice	3 ☐ Suicide 6 ☐ Could n	200. Fla	ce of Injury - At h	ome, farm, sti	reet, factory, office		28f. Location (S City or Tox	Street and Nu	ımber or Rui	ral Route Number,
5	after after din b	Certification;	4 Homicide	bui	ding, etc. (Specia	у)			Ony or 700	vii, Olato)		
	hours inera y fille	aic	29a. Certifier 1 Certifying	Physician: To t	he best of my kno	wledge, deat	h occurred at the tir	ne, date and place	, and due to the	cause(s) and	manner as	stated.
	To the Hospital or Attending Physician: The lwithin 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical E		basis of examina inner stated.	uon and/or in	vestigation, in my o	риноп, ават осси				
	To the To the Comp	Me	29b. Signature and title of certifier	1	A		29c. Licens			29d. Date sig		
			1 Chush	my the	ly.	no	1)2	5 205		JANU	Any.	21,2008
			30. Name and address of person w	vho completed ca	use of death (Iter	n 23a) (Type,	Print)	0 (1	1 1	IL. m	117	1:200
			W.A. Riley	69.	mc 6	701	M- Che	ullo IT	tal	100 11	CA S	120/2
	Sta		31. Date filed (Month, Day, Year)	32	Registrar's Sign	ature	white .					
	Regist	rar	JAN 29 2	2008	1492 83	Page 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SENTIR **Physician** 700M 08 0 /Medical 4c. County of Death 4b. City, Town, or Location of Death a. Facility Name (If not institution, give street and number, Examiner Prince George's 4519 Rising Lane Bowie If Under 1 Year Months Days 8. Date of Birth (Month, Day, Yea Aug. 23, 1 If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number 6 Sex **Funeral** Min. Hours 1 □ M 2 1 1921 Indiana 310-16-1425 86 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No Directo Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20715 USA Funeral 4519 Rising Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Baltimore, Maryland 21215-0036 Specify by White 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If Item 27 is marked other thar any Injury or other traumatic event, the Nonce. University of Indiana Medical Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Shellburn Howard Spear 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4519 Rising Lane Bowie, MD 20715 Harris Sentir/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Forest Hill Cemetery | 1/30/2008 | Shelbyville, IN 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licer 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Int**e**rvai Between and Death BREAST immediate Cause (Final disease or condition resulting in death) WIDERY TASTATIC **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 □ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 2□ No 1 ☐ Yes 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home Hospital: 5 Residence 6 □Other (Specify, Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury 28h. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t (Month, Day Year) 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1xt Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical 29a. Certifier he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number

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NICHAG J. Late N 31. Date filed (Month, Day, Year) 32.

2008

32 Registrar's Signature

HYR DEFENSE HIGHWAY ANNAPOLIS MOZIYOI

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 875 1-29-08vt lealth and Mental Hygiene 0 0 8 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) John, Joseph Shanev Jr. Month **Physician** mude aw /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner BULLIMORE MI If Under 1 Year | If Under 24 His 8. Date of Birth Wonth, Day, Year) 6. Sex. 1 ☑ M 2 ☐ F Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Yrs 215-14-9207 85 Maryland Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland II Hygiene. other than "natural", or Hems 23a or 28s-1 ehow 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2 No Director Baltimore Baltimore 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 4436 Scotia Road 21227 United States 12. Was Decedent Ever in U.S. Amed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction permit. Pages 1 and 2 should be filled.
Department of Health and Mental Hyg.
Important: If Item 27 is marked other any injury or other treuments. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Shaney Sr. Nettie Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nancy Johnson - Companion 4436 Scotia Rd., Baltimore, MD 21227 20b. Place of Disposition (Name of Gien Haven 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State □Donation 5 □ Other (Specify) 1-22-2008 Memorial Park Glen Burnie, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit Due to (or as a consequence of) Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed' 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours effer death.
To the Funerel Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Hornicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d, Date signed (Month, Day, Year, 29b. Signature and fittle of certified on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of

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State Registrar 31. Date filed (Month, Day, Year)

Calveton

32. Registrar's Signature

eatonsville 21928

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician**  $p^{M}$ 18, Hazel Pearl Scheminant 2008 5:30 January /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Genesis Eldercare-Hammonds Lane Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 🕏 F 216-12-6183 86 1921 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City. Town or Location 10a. State 1 ☐ Yes 2X No Director Baltimore Lansdowne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 35 Elizabeth Avenue 21227 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2½ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 → Married Specify: white 1 ☐ Yes 2 🗓 No Specify \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Riggleman Lulu Lough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Earl Scheminant/ Husband Elizabeth Avenue Lansdowne Md 21227 20b. Place of Disposition (Name of cemetery, cematory of other place)
Meadowridge Memorial
Park 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 01-24-2008 Elkridge, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ambrose Funeral Home of Lansdowne
2719 Hammonds Ferry Rd. Lansdowne MD 21. Signature of Funeral Sont 21227 Tart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumonia /Medical Due to (or as a consequence of): **Examiner** Due to (or as a consequence of) Dementir Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed and the burial-trar Due to (or as a consequence of): physician Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 : autopsy perform 1∐ Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this ( ٩ funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural
2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. al or Attend after death. the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Propertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WD

State Registrar

30. Name and a

JUde Muneres

31. Date filed (Month, Day, Year)

9 2008

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division or Vital Records,

Oakmood

ROAD Glen Parnie MD

dress of person who completed cause of death (Item 23a) (Type, Print)

7845

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 25 2008 **Physician** STACHOWSKI JANUARY 7:55p M KATHLEEN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 1227 LANDOVER ROAD ROSEDALE 8. Date of Birth (Month, Day, Year) 6 / 17 / 1933 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 M 2 X MARYLAND 74 212308408 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE ROSEDALE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1227 LANDOVER ROAD 21237 USA Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL ADMINISTRATION permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumant. MEDICAL 12 -0-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ MARGARET WARNER 2 RICHARD SCOTT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) EDWARD J. STACHOWSKI/HUSBAND ROAD ROSEDALE, MD 21237 1227 LANDOVER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1. Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) HOLLY HILL 1/29/08 BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 21237 1211 CHESACO AVENUE BALTIMORE MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ONAR /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine be executed burial-transit and Due to (or as a consequence of): Box 68760, physician Physician/Medical the IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death nse 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 1 Yes 2 No 9 Unknown 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. the 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>\$</u> 3 Probably 4 Unknown 1 Tyes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform<sub>é</sub> 2 No 1 ☐ Yes 1 Yes Division or Vital . Was case referred to examiner? 1 ☐ Yes 20 No 26. Place of Death (Check only one) funeral director Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of D After or Attending 1/X Natural 2 Accident 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 24 hours after death. ■ Funeral Director: A filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Or the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 2 Medical Examiner: Or within 2

State Registrar

8

29b. Signature and title of certifier

30. Name and address of person wh

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

2008

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29c. License number

redical Center

29d. Date signed (Month, Day, Year)

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Registrar

DHMH 17 Rev 1/2001

State

John

31. Date filed (Month, Day, Year)

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Serlemits 05

32. Begistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2044 Shuler Ebelita 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Medical Centre Baltimore University 01 If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2√2 F Philippine 53 Director 576-11-6495 March 16, 1954 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD. Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Ebbing Court 21221 Phili ppine Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Asian Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Old Line Plastic permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 any Injury or other traumatic event, the Meany Injury or other traumatic event, the Means Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sopriano Enago Juanita Calucer ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2633 E. Parkville, Md. 21234 Lolita Cole/ Sister Joppa Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) vans Funeral Chapet DIAIT 1/29/08 ForeSt Hill,
22. Name and Address of Facility
Evans Funeral Chapet and Cremation Services
22. Name and Address of Facility
Evans Funeral Chapet and Cremation Services M 21. Signature of Funeral Service Licenses 8800 Harford Rd. Parkville, Md. 21234 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician preumoni /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has e 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Tes 21 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funera 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 225 Greene St Baltimore, UD MD banna 32. Paristrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	Marylan		artment rtificate			and M	Я	eg. No:	2008	021	31
	Physicia	an	Decedent's Name (First, Middle, L. Ellen	J.		Sma	7 7				2. Date of Dea Month January	Day	. 2008°	3. Time of 4:40	A M
	/Medic	al	4a. Facility Name (If not institution, gi		er)	Jilla	4b. City, To	own or l	ocation o		oandar y		County of Death	7.40	*1
	Examin	er	Harford Memorial		.,				e Gra				Harford		
	Funeral			Sex 7.		last birthday)	If Under 1 Months	Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day March 2	Year)	9. Birth	place (State o	or Foreign
	Director		214-38-0912	1□M 2XF	8	7 Yrs.	WOTHIS	Days	riours		March 2	9,19	20 New		
	and w	}	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside C	ity Limits
	Maryli f eho	ō	Maryland Harford	3		Edgewo	od							1 🗌 Yes	2 <b>X</b> №
	r 28a-	rec	10e. Street and Number				10f. Zip C	Code				l 0g. Citiz	zen of What Cou	ntry?	
	h with	Funeral Director	1622 Swallow Cres	st Drive	Apt A			2104	40			US	SA		
	ems (	ner	11. Marital Status	12. Was Decede Armed Force	int Ever in U	.S. 13.	Was Decede	nt of His by Cuban	panic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	1	14. Race - Ameri Black, White,		
36	s afte	by F.	1 ☐ Never Married 2 ☐ Married  3 X Widowed 4 ☐ Divorced	1 ∐ Yes 2] If Yes, Give Year or Date	_		1□Yes 2	☐ No	Specify:				Specify: Wh	ite	
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28a-f ehow the Modical Examinar must be notified at	ed b	15. Decedent's l	Education		16a. Dece	dent's Usual	Occupat	tion			16b. Kir	nd of Business/Ir	dustry	
215	nin 72 n "ng Medik	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed)  College (1-4)	or 5+)	(Give	kind of work DO NOT use	done du retired)	<i>iring</i> mosi	t of works	ng				
21	giene grithe	Com	12 years			Re	ceptic						exon		
pu	tal Hy d oth	Be (	17. Father's Name (First, Middle, Last Harry O. Bailey	st)							(First, Middle. T. Jobe		Sumame)		
Z a	1 Men narke	ဥ	19a. Informant's Name/Relationship	(Time Print)		10h Maili	ng Address /	(Street 2)					r Town, State, Zi	n Code)	
Maryland	d 2 st th and t7 is n traun	ri	Clarence Bailey	Brotl	ner								irginia		
ē,	Heal		20a. Method of Disposition		20b. F	Place of Dispo cemetery, crea	sition (Name	e of		Janน์			cation - City or T		
OE .	Pages ent of nt: If i		1 XBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec			dens of						Rose	dale, Ma	arylan	d
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydiene. Important: if item 27 is marked other than "naturel; or items 23a or 28a-f show any highry or other traumatic event, the Modical Examinar must be notified at any highry or other traumatic event, the Modical Examinar must be notified at ange.		21. Signature of Fundral Service Lic	ensee	000	1 2	2. Name and Onnell	Addres Y F	s of Facilit	Y1 HC	ome Of D	Unda	alk,P.A.	21222	
			23a. Párt1. Enter the disease or co shock, or heart failure. List on	mplications that cau	sed the deal	th. Do not en	ter the mode	of dying	, such as	cardiac o	or respiratory ar	rest,	ישוא, וישט.	Approxima Interval Be	ite
. E	Physician		Immediate Cause (Final	y one cause on eac	h line.	4. F1	mat	3/4	Re	3 ma.	see 5	T #1 cd	( Comp	Onset and	
4	/Medical		disease or condition resulting in death)	a Due to (or	as a consec	quence of):		-/		1	/		ctione.		/
н	Examiner		Sequentially list conditions.	b. Enter	0000	cus	Oris	rarz	7	rne	T	n te	ction.		
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consec	quence of):									
	ate be executed hysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or	as a consec	quence of):				-					
760,	sicien buriz	caiE		d											
89	ifficate g phy as the								1200					-	
Вох	th cert endin r use	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. II yes, outco			⊒Ectopic pre	gnancy				1	23d. Date of deliver Month	ery Day	Year
	that the death certifica ed by the ettending ph detached for use as th	Physician/Med	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐ Pregnan 9☐ Unknow		death 5[	Other (spe	cify)					WOITH	Duy	1041
P.0	d by 1	Phy	Part II. Other significant conditions	contribution to deal	th but not res	sulting in the :	inderlying ca	use aive	n in Part I		23e. Did to	obacco u	ise contribute to	the cause of	death?
Records,	sign sign d be	ed by									101	es 2	No 3□Pro	bably 4	]Unknown
eco		Completed									24a. Was autop	SV	24b. Were aut	opsy findings ompletion of	s available cause of
E .	The law sete has b page 2 s	Con									perto 1 ☐ Yes	rmed? 2DX No	death?	2□ No	
Vital	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				A Othe			h Check only o				
of	Phys this al di	.T.	1 ☐ Yes 2 ♠ No 27. Manner of D ath	28a. Date of		28b. Time of			4 [ ] 144		me 5 ☐ Resid		6 ☐Other (Spec y occurred	ify)	
O	nding lath. r: After e funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month,	Day Year)	Injury	м	Bc. Injury Work	? ∕es 2 🗌						
Division	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	f Injury - At h , etc. <i>(Speci</i>	nome, farm, st	reet, factory,	, office			28f. Location (S City or Tox		d Number or Ru	ral Route Nut	m <i>ber</i> ,
	Hospital	Ce	29a. Certifier 1 Certifying	Physician: To the b	est of my kn	owledge, dea	th occurred a	at the tim	e, date ar	nd place.	and due to the	cause(s)	and manner as	stated.	
	he Hoi in 24 h he Fur pletely	Medicai	(Check only 2 Medical Ex	aminer: On the bas and manne	is of examin	ation and/or in	nvestigation,	in my op	oinion, dea	ath occur	red at the time,	date and	d place, and due	to the cause	
	with To t	Σ	29b. Signature and title of certifier	1 ~	<b>&gt;</b>		29c.	License	number	, / >		29d. Dai	te signed (Month	Day, Year)	J.F
,	1		30. Name and address of person wh			m 23a) (Type	, Print)		، در				te signed (Month		11
F	)		31. Date filed (Month, Day, Year)	LYNCH		) 5	01	5.	Unit	s is f	ave 1	avi	e del-	ace	ma.
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** January 2<sup>Day</sup> 2008 S. Schwatka Margaret 3:26 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Crofton Convalescent & Rehab. Center Anne Arundel Crofton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year 1/19/1919 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 □ M 2 M F 89 213-26-2902 Maryland **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland | Anne Arundel Gambrills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 998 Springhill Way 21054 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 1□Yes 2■No White Baltimore, Maryland 21215-0036 þ Specify: 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 6 Department of Health and Mental Hy, Important: If Item 27 is marked other any Injury or other trees. event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cora Bentz unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21054 Carl R. Thomas / Grandson 998 Springhill Way Gambrills, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Memorial Pk. 1/30/2008 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee Madit -2 4107 Wilkens Avenue Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) ana /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4' Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 3□ DOA P 2 ER/Outpatient 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 29b. Signature and title

31. Date filed (Month, Day, Year)

certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

DHMH 17 Rev 1/2001

208 C

29c. License number

29d. Pate signed (Month, Day, Year)

rain Hwy Sw Glen Burnie MD21061

08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:30 PM Mary Elizabeth Sullivan 1/21/2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Cheverly Prince George's Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1 □ M 2 🕅 F 85 1/3/1923 Washington, D.C 578-26-4807 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Prince George's College Park MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20740 9014 Rhode Island Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: White f Yes, Give Year or Dates: Ś 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygiene Important: If them 27 Is marked other the any Injury or other traumatic event, the once. Housewife 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Pixton Dewey Whaling 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3337 Oak Drive, Edgewater, MD 21037 Janet M. Lindsey, Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 1/26/2008 4 □ Donation 5 □ Other (Specify) Glenwood Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Ave. Hyattsville, MD 20781 Las Lanning Gasch's Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. D of t enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kidney Failure Physician disease or conditior resulting in death) /Medical Due to (or as a consequence of): Examiner Bilateral Pulmonary Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed Sepsis Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical Multiple Organ Failure 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4; ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No 1□ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: After (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1-23-08

Registrar
DHMH 17 Rev 1/2001

State

Drive

Cheverly MD 20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

3001 Hospital

32. Registrar's Signature

		-	For State Registrar	State of Ma	aryland /		riment of F		ı wenta	, ,	erie g. No. 2 ()	08	02131	and the
	Physici	an	1. Decedent's Name (First, Middle,	Last)						te of Death onth	Day	Year	3. Time of Death	
1987	/Medic	al	Virginia V. Sey							nuary	23, 2	2008	9:09 A M	_
	Examin	er	4a. Facility Name (If not institution, 15311 Beaverbro				4b. City, Town, or Silver	Spring				y of Death comery	7	
	uneral irector				e (In yrs. last b	virthday) Yrs.	If Under 1 Year Months Days			te of Birth onth, Day,		9. Birthp Coun	lace (State or Foreign	
рц	>		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	wn or Loc	ation					1	0d. Inside City Limits	_
laryla	shov ed at	ē	Maryland Montg	Omoru	Silve								1 □Yes 2 No	
the N	28a-I	Director	10e. Street and Number	omery	DIIVE	т эћ	10f. Zip Code			10	g. Citizen of	What Cour	ntry?	-
h with	3a or st be	al Di	15311 Beaverbro	ok Court			20906				Unite	ed Sta	ates	
: I Z I 3-UU36 within 72 hours after death with the Maryland ene.	of other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	y Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie	If Yes, Give		in U.S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 1 No Specify:					Bla	ce - Americ ck, White, fy: Whit	etc.	
<b>I ວ-ບບວຽວ</b> 72 hours af	tural"	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates:	16	a. Decede	ent's Usual Occup	ation		1	  6b. Kind of E	Business/Inc	dustry	
within 72 iene.	than "na the Medic	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5	i+)	(Give k life. D	ind of work done O NOT use retired etary	during most of w d)	vorking			cical	·	
and Z d be filled	other vent, tt	Be	17. Father's Name (First, Middle, L	ast)				18. Mother's N	lame (First,	Middle, M	laiden Surna	me)		
Maryland 2 should be f and Mental H	arked atic e	5	Lewis Richard V	oorhees				Bessi						_
Aar) 2 sho	If Item 27 is marke or other traumatic		19a. Informant's Name/Relationsh John P. Seymour			•	Address (Street Bowie Mi				•		Code)	
e, <b>E</b> 1 and 2 Health	Item 27 other t		20a. Method of Disposition	7 5011	20h Place	of Dispos	ition (Name of	- i _	nuary		20c. Location		own, State	-
Pages Pent of	y or c		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		Gate Ce	mata	atory or other place leaven		2008		Silver	Spri	ng, MD	
Saltimor permit. Pages Department of	Important: If any injury or once.		21. Signature of Funeral Service L			R <sup>22</sup> .	Name and Addre	rss of Facility 3	obert 00 We	A. P	umphre	ry Fur	reral Home, venue	f
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alor V	I Dire	ertil	4 ☐ Homicide determi	building, et	c. (Specify)				Ci	ity or Town	i, State)			
DIVISIO To the Hospital or Attend within 24 hours after death	To the Funeral Directory and the Completely filled in by	edical C		Physiclan: To the best examiner: On the basis of and manner st	f examination									
To th	To th comp	Me	29b. Signature and title of certifier	1.8 4.0			29c. Licens				9d. Date sign		-	
	./		· Robert	1			D3474	+U			Januar	y 23,	2000	_
•	35		30. Name and address of person values, Sobert Fields,					e. #200	. 01n	ev. M	D 2083	32		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registi	ar's Signature			_ ,	,	- , ,				-
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 25, 2008 20:00 January Sierra Bryan Anthony /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Suburban Hospital Bethesda Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days 1**X**IM 2□ F June 15, 1968 Puerto Rico 059-62-8431 39 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 □Yes 2 □ No Director Maryland Bethesda Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20817 6437 Rock Forest Drive Funeral 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Justice Press Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Enid Brezil Ange1 Sierra ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 82-11 262 Street, Floral Park, New York 11004 Brezil / Mother Enid 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 31, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 4 Donation 5 Other (Specify) Pinelawn MemorialPark Pinelawn, New York 21. Signature of Funeral Service Licensee Robert A. Pumphrey FuneralHome, Inc./Rockville M01193 300 West Montgomery Avenue, Rockville, Maryland 20850 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kaposi Sarcoma 2 Years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Number HIV Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2X No 1 🕅 Inpatient 3□ DOA 2 ☐ ER/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 🛚 Natural

Box 68760, attending physician 2000 = 1/2h for use Records, P.O. signed by t Id be detach certificate has **Division or Vital** this

Hospital

funeral director Hospital or Attending P 4 hours after death. Funeral Director: After 24 hours a

**Funeral** 

Director

e filed within 72 hours after death with the Maryland al Hyglene.
other than "natural", or Items 23a or 28a-f show

Saltimore, Maryland 21215-0036

"natural", or Items 23a or 28a-f show dical Examiner must be notified at

traumatic event, the Medical

n and Mental P

Health

Pages 1

item 27

**Physician** 

/Medical

Examiner

other 1

= 5 Department of Important: If any Injury or once.

To the Hosp within 24 hou To the Fune completely fi 15 29a. Certifier

2 Accident

3 ☐ Suicide

4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 ☐ Could not be

determined

M.O

D0059244

29c. License number

29d. Date signed (Month, Day, Year) January 26, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4416 East West Highway, Suite 410, Bethesda, Maryland 20814 Giselle Mery, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Medical



ORIGINAL

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State Registrar	State of Ma	aryland / De <sub>l</sub>		f Health a	nd Mental Hy	_	08 02136
12			Decedent's Name (First, Middle, La	st)				2. Date of D		3. Time of Death
	Physici		Stanley S	chuett				JAnuar	Day 22	2008 1922 M
	/Medic Examir	100	4a. Facility Name (If not institution, giv			4b. City, Tow	n, or Location of		4c. County	
		West.	Upper Chesape	ake		Bel	Air		HAR	
	Funeral		5. Social Security Number 6. 5		e (In yrs. last birthda	y) If Under 1 Your Months Da	ear If Under 2 ays Hours	Min. 8. Date of Bi	3 1921	Birthplace (State or Foreign Country)
	Director		502-05-6199	1 <del>Q</del> M 2 □ F	86 Yrs.			01 08	3 1921	N.D.
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	fanyla •ho	20		1	Bel Air					1 ☐ Yes 2 🔀 No
	28a-1	ect	MD Harford		Del All	10f. Zip Coo	de		10g. Citizen of \	What Country?
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(0	r iter	Fur	1 Never Married 2 X Marned	Armed Forces?	No			, Puerto Hican, etc.)		ck, White, etc.
8	ours a	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		IL Tes ZLA	No Specify:		Specify	White
2-0	within 72 hours after ene. then "natural", or ite ne Medical Exemina	Completed	15. Decedent's E (Specify only highest gr		16a. De	cedent's Usual Or ve kind of work di DO NOT use re	ccupation one during most	of working	16b. Kind of B	usiness/Industry
21	ithin Jen Ma	npl	Elementary/Secondary (0-12)	College (1-4or	5+)		etir <del>e</del> d)			
2	led w lygiei her ti		12 17. Father's Name (First, Middle, Lasi	4	E1	ngineer	18 Mother	r's Name (First, Middle		1 Sales
ang.	be fi	Be	George Schuett	,				ne Hamerli		,
₹ ∠	12 should be filed within 7 h and Mental Hyglene h and Mental Hyglene 7 le marked other then "; traumatic event, in a Max	2	19a. Informant's Name/Relationship	Type Print!	19h Ma	uling Address (St		r or Rural Route Num		State, Zip Code)
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 ie marked other then "natural", or items 23s or 28s-f ehow or other traumatic event, It a Madical Examinat mant by recition at		Jeannine Schuet		i			. Bel Air	MD 2101	
စ်	permit. Pages 1 and 2: Depertment of Health as Important: if Item 27 is eny injury or other trau once.	2	20a. Method of Disposition	/ WILE	20b. Place of Dis	position (Name o	of	Date	20c. Location	- City or Town, State
و آ	ages ant of it: If I		1 Burial 2 Cremation 3 ( 4 Donation 5 Other (Speci			ir Memor	1	01/26/08	Rol A	ir MD
Baltimore,	entme ontar injur		21. Signature of Europe Service Lice		Del A	22. Name and A				al Home Inc.
B	Deperment Deperm		Volul	4		9705 Be	lair Rd	. Nottingh	am MD 2	21236
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	/Medical		resulting in death)		a consequence of):					
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	11		30. Name and address of person who	completed cause of	death (Item 23a) (Ty		10 37	•	01/2	3/2000
	12+		SURESH DHANJA	wi, MD, 62	2 5.0200	QUE H	AVRE DE	GRACE A	40 21078	7
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		I- For State Registrar 1. Decedent's Name (First, Mid	dia Lask)		Certific	ate of	Death			. 12	Re Date of Deat	g. No.	211	3 Time	of Death
Physicia Medical Examin		FREDERI		SCHM	1 ፓ ጥጥ						Month January 24	 Day 4. 2008	Year	1	9 hrs
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any	ł	10a. State 10b. Count	у	10	c. City, Town	or Location	on								ide City Limits
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Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after dee Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner mu		Continue of	2	r Late		70	DLLY 00 S.	& cc	NKL	ER ING	INC. I STŘEI	UNE ET.B	RAL F ALTO	IOME MD	21224
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Divisior e Hospital or Attend 1.24 hours after death e Funeral Director:		29a. Certifier 1 Certifying	Physician: To the b	est of my i	knowledge, d	eath occur	rred at the ti	ime, dat	e and pla	ce, and o	due to the cau	ise(s) and	d manner as	stated.	
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10		30. Name and address of pers David Fowler M.D.	on who completed ca Chief Medical				treet, Ba	ltimore	e, MD 2	21201					
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08-00415 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Dale Edward Smith State of Maryland / Department of Health and Mental Hygiene 2008 02138 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day January 15, 2008 Medical Examiner 0037 hrs Dale Edward Smith 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Easton Memorial Hospital Easton Talbot 5. Social Security Numberunk **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours CountryMaryland 49 Oct 15, 1958 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show must be notified at once, 1 Yes 2X No MD Caroline Goldsboro Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15747 Fair Haven Lane 21636 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 X Never Married White, etc. Yes 2 X No Widowed Divorced f Yes. Give Year Yes 2 X No specify: white ģ Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dorld  $\mathbf{n}$ 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk construction 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Clfford Smith Julia Cansbury ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Grabarek/sister Rochelle Road Norwalk, CT 06854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Burial 2 Cremation 3 crematory or other place) Donation 5 X Other Specify: Signature of Funeral Servi Ronald S. Wade 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 art I. Enter the diseale, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval falure. List only one cause on each line /Medical Between Onset and Death Atherosclerotic cardiovascular disease taminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical physician a X UNPENDED To the Hospital or Attending Physician: The law requires that the death certificate be <u>perME,g</u>875, 1/30/08 TT Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day Year past 12 months? Month Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ σ, Yes 2 No 3 Probably 4 ✔ Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other 4 this Inpatient 2 V ER/Outpatient 3 DOA ٩ 1 V Yes Nursing Home 5 Residence 6 After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu X Natural Pending Yes 2 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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OCMF 2006

State

29b. Signature and title of certifier

Denna

31. Date filed (Month, Day, Year)

Donna M. Vincenti, MD

Assistant Medical Examiner

menti miD

30. Name and address of person who completed cause of death (Item 23a)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 15, 2008

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

**Physician** /Medical Examiner 21. Signature of Funeral Service Licensee

burial-transi physician and the

Box 68760

Division or Vital Records, P.O.

To the Hospital or Attending Physician:

within 24 hours after death. To the Funeral Director: ₱

2 Accident

3 Suicide

29a. Certifier

Medical

State Registrar 4 ☐ Homicide

11CHAQ 31. Date filed (Month, Day,

Signature and title of c

6 ☐ Could not be

Year

determined

the has t this After

weste 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2/1 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home Hospital: 5 Residence 6 □Other (Specify) 1 🗌 Yes 1 Inpatient 3 DOA 2 ☐ ER/Outpatient 2 27. Manner of Death 1 Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation

M

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

mpleted cause of death (Item 23a

1 Tyes 2 □ No

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

22. Name and Address of Facility Robert E. Evans Funeral Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, Month 11:30 PM **Physician** aylor 25 Januar seph /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner xtended Date of Birth (Month, Day, 9. Birthplace Country) Age (In yr. Social Security Number **Funeral** Months Days Hours 1 M 2 □ F 219-16-4430 Usual Residence of Decedent Director the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 10a, State 1 Yes 2 No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code o e Pages 1 and 2 should be filed within 72 hours after death with 2/2 r Items 23a o by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American I Black, White, etc. 11 Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No ō Baltimore, Maryland 21215-0036 Specify. 3 ☐ Widowed 4 ☐ Divorced K "natural", er than "nature the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mones. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be ဥ 19a. Informant's Name/Relationship (Type. Print) ( 9 Wardia) 19b. Mailing Address (Street and Number or al Route Number, City or Town, State, Zip Code, # Berna 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 2008 5 ☐ Other (Specify) 4 ☐ Donation 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Joseph 222 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease) Approximate Interval Between Onset and Death Sease OVONOV **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ngestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4⊡Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 4 Unknown 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 Yes 1☐ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 No Hospital: 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 3 DOA Certification: To 1 Yes in by the funeral 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? After (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
George E. Wicks M.D. 3900 Loch Raven Boulevard Marylan. 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			Plea	se Type or							-		•		
		For State Registrar		State of	of Maryla			ment of F ficate of			lental Hy	/giene Reg. No	$-2\Pi\Pi$	8 0	2143
4 4		1. Decedent's Name	e (First, Middle	e, Last)							2. Date of D	eath Da	ay Year	3. Ti	me of Death
Physicia /Medic	_		LOIS	JANE T	AYLOR						Januar	y 25	2008		ll a <sup>M</sup>
Examin	er	4a. Facility Name (I	f not institution	n, give street and no	ımber)		4t	o. City, Town, o		of Death		4c. County of Death			
À		SINAI  5. Social Security N	HOSPIT	AL 6. Sex	7. Age (In yr	s. last birth	day) If	BALTII Under 1 Year	If Under		8. Date of B	irth ,	N/A 9. Bi	rthplace (S	tate or Foreign
Funeral Director		212-36-8		1 □ M 2 □ X EX			rs. M	lonths Days	Hours	Min.	(Month, E MAY 1	ay, Yea <i>r</i> 2 19	37 M	ountry) ARYLA	ND
pu ,		Usual Residence of	Decedent		100.0	City, Town	or Locatio	on						10d. Insi	de City Limits
show	5	10a. State	10b. County	_	100. 0										]Yes 2 □ No
the N 28a-f notifie	rect	MARYLAND  10e. Street and Nur	M/A	Α		BF	ALTI	10f. Zip Code				10g. C	itizen of What C	ountry?	
3a or	Ē	2648 O		AVENUE				212	215			U	.S.A.		
ems 2	Funeral Director	11. Marital Status		12. Was Dec	cedent Ever in orces?	U.S.	13. Was	s Decedent of les, specity Cub	Hispanic O pan, Mexica	ngin? (Span, Puerto	ecity Yes or N Rican, etc.)	0-	14. Race - Am Black, Wh		an,
s after	by Fu	1 ☐ Never Marri 3 ☐ Widowed		I If Yes, G	2 🛣 No live Dates:		1 🗆	Yes 2🛛 No	Specify	<i>'</i> :			Specify: BL	ACK	
hour tural		3 🗆 Widowed		t's Education	Dates.	16a. D	Decedent	t's Usual Occu	pation			16b. I	Kind of Busines		
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nd 2 sulth an 27 is urrau				lor/Grand	daughte		-	•					ryland		i
of Heal		20a. Method of Disp	position		20b	. Place of I	Dispositio	on (Name of ory or other pla	ace)	[	Date	20c. l	Location - City of	r Town, Sta	ate
Page ment c ant: If ury or		1 ☐ Burial 2 4 ☐ Donation		3 □Removal from Specify)	MI	ETRO (	CREM	ATORY		01-28	8-08	BAI	TIMORE,	MARY	LAND
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	uneral Service	Licensee			WIL	lame and Addr LIAM C	BROW	N COM	MUNITY	FUN	ERAL HO	ME P.	Α.
20 = 40		23a Parti Enter t	Mu Ca	r complications that	caused the de	eath. Do no		06 W NO				arrest.			ximate
Dhysisian		shock, or hea	art failure. Lis	only one cause on	each line.	1.					12:10			Onse	al Between t and Death
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Examiner		Sequentially list co	anditions	b	Hy	per	ten	الماري د						84	ears
sit ad	iner	if any leading to in cause. Enter Under Cause (Disease or	mmediate erlying -	Due to	(or as a cons	equence of	f):							8	yeurs a
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w requires that the death certific been signed by the attending p should be detached for use as	Physician/Medi	IF FEMALE: 23b. Was deceder in the past 12		1 ☐ Live	utcome pf preg birth 2   F	etal death		ctopic pregnan	су				23d. Date of d Month	elivery Day	Year
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that the by detact	y Ph	Part II. Other signi	ificant condit	ions contributing to	death but not r	esulting in	the unde	erlying cause g	iven in Parl	ı.	23e. Di	d tobacco	use contribute	to the caus	se of death?
quires en sigr uld be	ed by										1[	] Yes	21210 3□	Probably	4 □Unknown
law re as bee 2 sho	Completed										24a. Wa	as an topsy	prior t	o completic	dings available on of cause of
	Com										pe 1□ Yes	rformed?	death No 1 ☐ Y		lo
Attending Physician: The law r death. ector: After this certificate has by the funeral director, page 2 s	Be	25. Was case refe examiner?		Hospital:		Veno.		2 POA   0	thor		th (Check onl		a Flau (2		
Phys er this eral di	: To	1 ☐ Yes 2 ☐ 27. Manner of ☐ a		28a. Dat	Inpatient 2	28b. Ti	ime of	3 □ DOA O		Nursing Ho			6 ☐Other (S <sub>i</sub> jury occurred	респу)	
ath. r: Afte	atior	1 Natural 2 ☐ Accident		igation	onth, Day Year	) In	njury		Yes 2	□No					
ir Atte ter dea Irecto I by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □ Could deterr	ninod Zoe. Fla	ce of injury - At Iding, etc. <i>(Sp</i> e	t home, far ec <i>ify)</i>	m, street	t, factory, office	9			(Street own, Sta	and Number or ate)	Rural Rout	e Number,
pitai c		29a. Certifier	1□ Certifyi	ng Physician: To t	he hest of my l	knowledge	death o	ccurred at the	time date	and place	and due to t	ne cause	(s) and manner	as stated.	
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only one)	2 ☐ Medica	I Examiner: On the	basis of exam anner stated.	ination and	d/or inves	stigation, in my	opinion, d	eath occu	rred at the tin	ie, date a	and place, and o	lue to the c	ause(s)
To th within To th сопр	Me	29b. Signature and	d title of certifi	er /	. /			29c. Licer	nse numbe			29d. [	Date signed (Mo	nth, Day, \	'ear)
<b>&lt;</b> 1		1	mhia	Z. V			7 km		162	<u>ا ۵</u>		1/	28/	08	
6		30. Name and add	doess of person	who completed ca	^	tem 23a) (7 セルレビ		int) So	h.alt, m.	ROL	man	y, my (	2121	7	
Sta	ite	31. Date filed (Mor		) 32.	Registrar's Sig		Base	EAR)		-					
Registr	ar		JAN 2	9 2008	A STATE OF	Jago.	17	1.00							

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Of Ma	Ce	ertificate of l			Reg. No. 2	8 02166
	Physicia	an.	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	ath Day Yea	3. Time of Death
	/Medic		Rosa M. Taylor				Januar		
	Examin	er	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of De	
			MD Masonic Homes  5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday		ysville If Under 24 Hrs.	8 Date of Birt	Bal	timore Birthplace (State or Foreign
	Funeral Director	1	216-44-0422  Usual Residence of Decedent	94 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da July 3	y, Year) 0,1913 N	Country)
	rland ow		10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	Mary a-f sh	tor	MD Baltimore	Cocke	eysville				1 ☐ Yes 2 No
	th the or 284	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
	23a cust b	la	300 International Cir.			21030		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral I	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Armed Forces?  1 □ Yes 2 ☒ If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race - Ai Black, W Specify:	merican Indian, hite, etc. White
9	72 hou	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occup	ation	ina i	16b. Kind of Busine	ss/Industry
Maryland 21215-0036	within 7 iene. • than "r the Med	Completed	Elementary/Secondary (0-12) College (1-4or 5	i+) life.	DO NOT use retired	t)	nig	Own Ho	me
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/lar	Menta Menta arked	ToE	John Dawson			Lill:	ie Dell	Wilson	
lar)	2 sho and I is ma		19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ing Address (Street	and Number or Run	al Route Numbe	er, City or Town, State	e, Zip Code)
	s 1 and 2. of Health a item 27 is other trau		David Taylor/ Son	20b. Place of Disp	ook Farm			1e, MD 210 20c. Location - City	
Baltimore,	Pages 1 ment of H ant: If ite ury or ot		20a. Method of Disposition  1 ☐ Burial 2 X Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	Metro Cre	ematory or other plac	Jan. 2008		Baltimor	,
Balt	permit. Departi Importa any Inj once,		21. Signature of Funer in Strvice Licensee  Michael J.	Flagle 10	22. Name and Address emmon Fune ) W. Padon	ss of Eacility Pral Home	of Dula	aney Valle um, MD 210	y, Inc. 93
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li						Approximate Interval Between
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	nsit A ted	nine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a consequence on.					
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	tificat ig phy as th								
D. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director; After this certificate has been signed by the attending physician and Completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	′		23d. Date of Month	delivery Day Year
P.O.	that the ed by detac	Ph	Part II. Other significant conditions contributing to death b	ut not resulting in the	underlying cause give	en in Part I.	23e. Did to	obacco use contribute	e to the cause of death?
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ita	lan: rtifica stor, p	BeC	25. Was case referred to medical			26. Place of Deat		-	
<u>-</u>	hysice his ce I direc	70 E	examiner? 1 ☐ Yes 2☑No Hospital: 1 ☐ Inpatie		ent 3□ DOA Oth	er: 4 Nursing Ho	me 5 🗆 Resid	dence 6 □Other (S	pecify)
n o	Ing P		27. Manner of Death  1 ⊠Natural 5 □ Pending (Month, Da	y Year) 28b. Time o	Wor	ƙ?	28d. Describe i	how injury occurred	
Sio	ttend Jeath. Stor: / the fi	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of interest.	ury - At home, farm, st		Yes 2 □ No	28f Location (	Street and Number or	Rural Route Number,
Division or Vital Records,	al or A after of I Direct	Certification:	determined 200.1 lace of my	c. (Specify)	reet, lactory, office		City or Tov		Transa Troate (variable)
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one)  1. Certifying Physiclan: To the best 2 Medical Examiner: On the basis of and manner state.	f examination and/or it					
	To the	Me	29b. Signature and title of certifier		29c. Licens			29d. Date signed (Me	
			1. Telesto, Ms.		Do	31464		1-25-	08
7	1		30. Name and address of person who completed cause of d	eath (Item 23a) (Type	, Print)				
	5		ROBGET LIBERTO, NO. 3,503	Brank 9	Print)  F BAZT	y noch.	21227	<i>f</i>	
	Sta Registr		31. Date filed (Month, Day, Year) 2008 32, Registr	ar's Signature	cale		,		

Rosa M. Taylor

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Mary		artment of H rtificate of I				
K	DE POL		Registrar  1. Decedent's Name (First, Middle, La	ist)		Timeate of i	Jean	2. Date of Deat		3. Firmé of Death
×	Physicia			teven	To	lson		Month January	Day Year 23, 2008	22:30P M
	/Medic Examin		4a. Facility Name (If not institution, give				Location of Death		4c. County of Dea	
			Southern Mary			Clin	ton If Under 24 Hrs.	8. Date of Birth	Prince C	George's
В	Funeral Director		5. Social Security Number 6. S 220–54–0898	Sex 7. Age (# 1 X 2 F 56	n yrs. last birthday) Yrs.	Months Days	Hours Min.	(Month, Day, Dec. 9,	Year) Co	shington, DC
	and w t	2	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary -f sho	tor	Maryland Prince (	George's	Clint	ton				1 □ Yes 2 □ No
	h the or 28a	Director	10e. Street and Number	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10f. Zip Code		1	0g. Citizen of What Co	ountry?
	23a c ust be		9119 Simpson Lar			2073.				.S.A.
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Marital Status  2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:	l l	Was Decedent of H If Yes, specify Cuba  1 ☐ Yes 2 No	llspanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
5-0	72 ho 'natur dical	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	dent's Usual Occup	ation during most of worki d)	ing	16b. Kind of Business	/Industry
121	within iene. than "	mp.	Elementary/Secondary (0-12)	College (1-4or 5+)			2)		Retai1	
2	a filed v al Hygie other t /ent, th	ပ္သို	12th 17. Father's Name (First, Middle, Lasi	t)		ashier	18. Mother's Name	e (First, Middle, I		
Maryland	ould be Mental rarked o	To Be	Alfred R.	Гolson. Jr.			Evelv	n Dilla	ard	
ary	2 should be and Menta is marked raumatic ev	-	19a. Informant's Name/Relationship		19b. Maili	ing Address (Street			r, City or Town, State,	Zip Code)
Σ	1 and 2 Health a em 27 is		Evelyn V. Bass						stville, MI	
ore	of He of He if iten		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □	☐Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of ematory or other place	ce)   Jan.	30,	20c. Location - City or	rTown, State
E m	. Pages tment of tant: If it		4 □ Donation 5 □ Other (Speci	ify)	Washingto	on Nation			Suitland,	
Baltimore,	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service Lice	1//	0153	2. Name and Addre			al Home, Ir 7 Road Clir	nc. nton, MD20735
	17.00		23a. Part1. Enter the disease, or con shock, or heart failure. List only	inplications that caused the one cause on each line.	e death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between
1 1 1 1	Physician		Immediate Cause (Final disease or condition	a Gasi	voint+	stina	1 hema	21160	9-2	Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):	11/6	0.0			
~	Lxammer	7	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	onsequence of):	VIIC	41			
	nsit A ted	Examiner	Cause (Disease or injury	200 10 (01 010 010	,					
Ć,	execunary and and lal-tra	Exal	that initiated events resulting in death) Last	C. Due to (or as a co	onsequence of):					
68760,	ficate be executed physician and the burial-transit	edical		_d						
_	ertifica ing ph e as th	Med	IF FEMALE:							
P.O. Box	The law requires that the death certificate be executed to has been signed by the aftending physician and the has been signed by the aftending physician and the has been seen the burial-transitions.	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	Day Year
	s that ined b	by Pl	Part II. Other significant conditions			underlying cause giv	ven in Part I.		bacco use contribute t	
or Vital Records,	w require been sig should b		12650/ (e)	1 Corcino	ma of 1	eft fen	ple	1 U Y	es 2∐No 3∐F	Probably 4 10 nknown
ecc	has be	Completed	Anemia		,			24a. Was a autop:	sy prior to	utopsy findings available completion of cause of
<u> </u>		Con	Respira	tory for	Yor e			perför 1□ Yes		s 2₽No
Vita	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:		nt 30 DOA Oth	26. Place of Deat			
or	ding Physician: h. After this certifica funeral director, I	- To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatie	SIIL 3 DOA	4 LI Nursing Ho		ence 6 Other (Spe ow injury occurred	ecify)
on	Jing I. Afte fune	tion	1 Accident 5 Pending investigation	(Month, Day Y	ear) Injury		rk?  Yes 2 □No			
Division	il or Attending after death. I Director: Afte d in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not to determined			treet, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	edical C	29a. Certifier (Check only one)	Physician: To the best of naminer: On the basis of ex and manner stated	(amination and/or i	ith occurred at the ti nvestigation, in my	me, date and place, opinion, death occur	red at the time, o	date and place, and du	ue to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	En	5	29c. Licens	<b>3</b> 7060		29d. Date signed (Mor	5005
	3		30. Name and address of person who	O Raigsed	294.n	, Print)	0188	DYON .	1/1/ Pa	45 701
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's	Signature	well	J. FUY! I	11/	11	/
	Regist	rar	JAN 292	UUS John Sulle	10 18					

State

Ge/nevieve Wroblewski,

JAN 29

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

EAST

30 Name and address of person who completed cluse of death (Item 23a) (Type, Print) Hosain MID

2008

29

32. Registrar's Signature

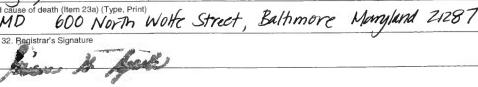
hair sheet westminster on 21157

State Registrar

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD



Carolyn

Res-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mary Frances Vacchi January 22, 2008 1:10 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Medical Center Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🖾 F 234-38-4677 82 Dec. 29, 1925 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Cheverly Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20785 USA 2813 Laurel Avenue 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Library of Congress Personnel Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marguerite Dugan Patrick Curley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2813 Laurel Avenue, Cheverly, Maryland 20785 Thomas R. Vacchi Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ⊠Removal from State 1/28/2008 Parkersburg, West Virgin Mt. Carmel Cemetery 4 Donation 5 Other (Specify) 4739 Baltimore Ave., 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781 -danne 23a. Part1. Enter the disease, or complications that caused the death. Do-not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1 month Pulmonary Tuberculosis disease or condition resulting in death) Due to (or as a consequence of) 1 month Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 3 weeks Sepsis Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery dent pregnant 3 Ectopic pregnancy Month Day 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 2X No 9 Unknown own 23e. Did tobacco use contribute to the cause of death? gnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

**Physician** /Medical **Examiner** The law requires that the death certificate be executed physician and s the burial-trans

Department of H important: if ite any injury or of once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show notified at

"natural", or items 23a or

Director

Funeral

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Completed

Be

2

death with the Maryland

altimore, Maryland 21215-0036

NACH!

Examiner Physician/Medical signed by the a d be detached f þ Completed Be ၉ Certification:

this

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was deced in the past 1 ☐ Yes 9 ☐ Unkno
Part II. Other si

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

27. Manner of Death

29a. Certifier

(Check only one)

24a. Was an	
autopsy	
performed?	
1□ Yes 21 No	

				20.	Flace of Deal	in (Oneon Only One)	
Н	ospital: 1≰∏npatient	2 ☐ ER/Outpatient	3□ DOA	Other: 4	☐ Nursing H	ome 5□Residence	6 □Other (Specify)
,	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c.	Injury at Work? 1 ☐ Yes		28d. Describe how in	jury occurred

1 X Natural 2 ☐ Accident	5 Pending investigation	(Month, Day Year)	Injury	М	1 [
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At ho building, etc. (Specif	ome, farm, stre	et, facto	ory, office

1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certi	1 17/1/10	eli M

29c. License number 10058213 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

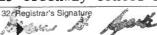
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Farhad Jamali, MD-7525 Greenway Center Drive, Greenbelt, MD 20770

Registrar

Medical

31. Date filed (Month, Day, Year) JAN 29 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 1 - For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JP 0530 M WILSON **Physician** 2008 DI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12220 Wynmore Lane Prince George's Bowie Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Sey 1M2 M 2□F 5. Social Security Number **Funeral** Months Days Hours Min. 39 09/21/1968 Director 219-64-5729 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County iral", or Items 23a or 28a-f show Examiner must be notified at 1√1Yes 2 No Director Maryland | Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12220 Wynmore Lane 20715 U.S.A. by Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Bar Tender Restaurant permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Millie Ann Hav Harry Livingston Wilson, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12220 Wynmore Lane, Bowie, Maryland 20715 Millie Ann Wilson /Mother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakemont Memorial 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 01/30/2008 Davidsonville, Md. 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed Yes 2 1□ Yes or Attending Physician: 26. Place of Death (Check only one 25. Was case referred to medical examiner? director. Be Other: Hospital: 20 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 \sum Nursing Home 5 Residence 6 □Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury at Work? After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide within 24 hours at To the Funeral D completely filled i the Hospital 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c, License number EFENSE HIGHWAY AMNAPOLISMO 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 29 2008 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 24,2008 ea **Physician** 06:39A M Hilda May Wilson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Towson Gilchrist Center 8. Date of Birth May 1, 1912 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 🗆 M England <del>XX</del>F 95 215-40-9385 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 N Directo Towson Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21204 USA 1860 Circle Road by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify:White 1 ☐ Yes 2X No Maryland 21215-0036 Specify XXWidowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Armitage George Feltham Evelyn Hilda 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DTR 1860 Circle Road Towson, Maryland 21204 Vivienne Wilson Haines Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20с. Location - City or Town, State Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 Removal from State Jan 25, 2008 GreenMount Crematory Baltimore, Maryland □Donation 5 □ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc gnature of Funeral Ser 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or cordition) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Wohl deus **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed led by the attending physician and detached for use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 H No 9 ☐ Unknown 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 2 1 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 200 No Hospital: 6 Other (Specify) Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation of Hospital or A. O4 hours after death. on Director: A' ov the 1 □ Yes 2 □ No <sup>1</sup>2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 | Homicide To the Hospital of within 24 hours at To the Funeral D 🛀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 12 30. Name and address of person w

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

#### State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Carol Diane Wiederock /Medical 4b. City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8415 Bellona Lane, Apt. Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1□M 2MF 65 368-40-8748 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State a or 28a-f shot be notified a Baltimore Towson MD Director 10e. Street and Number 10f. Zip Code 8415 Bellona Lane, Apt. 317 21204 an "natural", or Items 23a Medical Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 27 Is marked other that traumatic event, the I Store Manager 10 17. Father's Name (First, Middle, Last) Be Donald Dean ၉ 19a. Informant's Name/Relationship (Type. Print) 19 f Health George J. Wiederock/Son Important: If item any injury or other once. 20b. Place 20a. Method of Disposition Hillt Corpo 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or compli ations that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LARYNGEAL **Physician** /Medical Due to (or as a consequenc Examiner CARDIO PULM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenc Examine physician and sthe burial-trans Due to (or as a consequenc Physician/Medical attending pt 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting ð Completed

PRAY BLANCO MO

30. Name and address of person who completed cause of death (Item 23a

WORTH CHARLES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

First, Middle, Last)	)		18. Mother's Name	(First, Middle, Maide	п Surname)				
d Dean			Zella Rose Piehl						
me/Relationship (	Type. Print)	19b. Mailing Address (Street	et and Number or Rural Route Number, City or Town, State, Zip Code)						
. Wiederd	ock/Son	American Emba	issy, Ammar	n, Apo, AE	09892				
osition	20h PI	ace of Disposition (Name of emetery, crematory on other pla I top Service poration	D:	ate 20c. I	ocation - City or To				
neral Service Licer		22. Name and Addre	Road, Tows		Funeral H 1204	ome, Inc.			
rt failure. List only	plirations that caused the death one cause on each line.					Approximate Interval Between Onset and Death			
Final	a. LARYNGER	IL CANCER WI	THI METAS	57ASIS (57	MGEIVI				
	Due to (or as a consequ								
nditions,	b. CARDIO PUL	monany De	2007						
mediate rlying	Due to (or as a consequ	ence or):							
injury .ast	c Due to (or as a consequ	ence of):							
•	d								
pregnant months? 1No	23c. If yes, outcome pf pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic pregnand	ey N/A		23d. Date of deliver	ery Day Year			
icant conditions	contributing to death but not resu	Iting in the underlying cause gi	ven in Part I.		use contribute to the	he cause of death?			
-				24a. Was an autopsy performed?	death?	opsy findings available impletion of cause of			
red to medical			26. Place of Death	(Check only one)					
No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient 3 DOA Ot	her: 4 ☐ Nursing Hon	ne 5 Residence	6 □Other (Specif	(y)			
n 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)		ıry at 2 vrk? ] Yes 2 ☑ No	28d. Describe how inj	ury occurred				
6 Could not be determined	1017	me, farm, street, factory, office	2	28f. Location (Street a City or Town, Sta	and Number or Rura te)	al Route Number,			
1 Certifying Ph 2 Medical Exar	nysician: To the best of my know miner: On the basis of examinat and manner stated.	wledge, death occurred at the ion and/or investigation, in my	time, date and place, a opinion, death occurre	and due to the cause ed at the time, date a	(s) and manner as s nd place, and due t	stated. o the cause(s)			
title of certifier	CO MO DE	29c. Licen DOC 23a) (Type, Print) LTMORE M	se number 6 4365		ate signed (Month,				
	completed cause of death (Item	23a) (Type, Print)		uest	parllin	<i>3</i> 7			
ORTH CHI	ARUGS ST BA	LTIMORE M	10 2120	4 Sull	e 200				
JAN 2 9	2008 32. Registrar's Signat	ure facility							
		ORIGINAL							

Rea. No.

Day

4c. County of Death

10g, Citizen of What Country?

USA

14. Race - American Indian, Black, White, etc.

Specify: White

16b. Kind of Business/Industry

Retail

Baltimore

Michigan

PM

12:10

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

2. Date of Death

01-27-08

8. Date of Birth 01-03-1943

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: : After thi Director: To the Funeral within 24

Be

P

Certification:

Medical

25. Was case referred to medical examiner?

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

6569

4 ☐ Homicide

State Registrar

12

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

HMATUN

31. Date filed (Month, Day, Year)

Amoration M Meccan

JAN 29

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EEM

501

32. Registrar's Signature

29c. License number

phin streat

15503

29d. Date signed (Month, Day, Year)

anyary 29 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U 8 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:29 P M 16, 2008 January Eugene Wyatt Kenneth /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie 6. Sex 1X M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Days **Funeral** Months Maryland August 1,1945 62 Director 218-42-5003 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland Hygiene. 10c. City. Town or Location 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 1 ☐ Yes 2 No Director Anne Arundel Severn Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21144 1239 Reece Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🗓 No Specify: Baltimore, Maryland 21215-0036 White 2 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired)
Truck Driver/
Funeral Director Assistant 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) Crystal Water Company/ College (1-4or 5+) Elementary/Secondary (0-12) Funeral Home & Crematory 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any Injury or other traumatic event. Be Myrtle Bussey Mae Wyatt 2 Washington George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Severn, Maryland 21144 1239 Reece Road Maryland Sue Wyatt/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, Maryland Glen Haven Mem. Park 1/19/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. Signa we of Funeral Service Lic Odenton, Maryland 21113 stinai 1411 Annapolis Road 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) 10 days Anoxic Brain Injury **Physician** /Medical Due to (or as a consequence of) **Examiner** 10 days Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and be detached for use as the bunal-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Tyes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be ( funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ☐ ER/Outpatient 3 DOA 1 ☐ Yes 2 📉 No 1 🕅 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No after death.

I Director: A

d in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide filled in by 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie, January 16, 2008 D0055703 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 Hospital Drive Glen Burnie, Maryland 21061 Tsion Berhane, M.D. 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State JAN 2 9 2008

DHMH 17 Rev 1/2001

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1_ For State	ate of Maryland		ent of He cate of De					
		Registrar  1. Decedent's Name (First, Middle, Last)			ale or Di		2. Date of Dea		3. Time of Death 5	
_	ician	KERMITT	WHEE	LER			JAN.	Day Yea 200		
	edical miner	4a. Facility Name (If not institution, give stree UNIVERSITY OF MARYL			City, Town, or Lo			4c. County of De	eath	
Funer Direct		5. Social Security Number 474–28–5647  Live Paristress of December	7. Age (In yrs. la	Mor		f Under 24 Hrs { Hours Min.	3. Date of Birth (Month, Day 5/26/1	9. E 930 M	sirthplace (State or Foreign Country) LSSOURI	
/land low at		Usual Residence of Decedent  10a. State 10b. County	1 **	Town or Location					10d. Inside City Limits	
e Mary Ba-f sh tiffed a	ctor	MD HOWARD	CC	DLUMBIA					1 X Yes 2 No	
th with th 23a or 28 ust be no	Funeral Director	10e. Street and Number 11157 WOOD ELYES W	AY		f. Zip Code	21044		10g. Citizen of What		
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 221 fi marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fune	3 ☐ Widowed 4 ☐ Divorced	Vas Decedent Ever in U.S		Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☑ No Specify:			No- 14. Race - American Indian, Black, White, etc.  Specify: BLACK		
21215-0036 d within 72 hours af gjiene. er than "natural", or the Medi al Exami	Completed	15. Decedent's Educatio (Specify only highest grade co	n npleted)	16a. Decedent's (Give kind of life. DO No	Usual Occupation work done duraged of the contract of the cont	on ring most of working	9	16b. Kind of Busines	ss/Industry	
2121 I withir giene.	a Lo	Elementary/Secondary (0-12)	College (1-4or 5+)		L ANALÝ	ST		FEDERAL (	GOVERNMENT	
Maryland 2 nd 2 should be filed v lith and Mental Hygic 27 is marked other	To Be C	17. Father's Name (First, Middle, Last)				8. Mother's Name (	RVIN			
Mary d 2 sho th and 1 7 is me		19a. Informant's Name/Relationship (Type. I	. '					or, City or Town, State ${ m SIA}$ , ${ m MD}$ 21		
Baltimore, Maper permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tran		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo	20b. Pla	ace of Disposition metery, cremator UMBIA ME	y or other place)		1te 108	20c. Location - City		
Baltimore, bermit. Pages 1 a Department of Hes Important: If Item any inlury or othe	nce.	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	O ak	22. Nar	ne and Address	of Facility HOWE	ELL FUN	ERAL HOME		
m 205 g	O	23a. P.M. Egfer the disease, or complication of learn failure. List only one care	ons that caused the death,					SUP,MD 207	Approximate	
Physicia	an	shock, or leart failure. List only one co- lmm or unuse (Final diseas or condition	ause on each line.						Interval Between Onset and Death	
/Medic	al	resulting in death)	Due to (or as a consequent	ence of):					2 1122110	
Examin		Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):			_			
cuted	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events  c								
58760, cate be executed physician and the burial-transit	edical Ex		Due to (or as a consequ	ence of):						
Box 6 sath certifi	ian/Me	IF FEMALE: 23c. 23c. in the past 12 months? 1 □ Yes 2 □ No	f yes, outcome pf pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de	death 3 □Ecto	pic pregnancy er (specify)			23d. Date of Month	delivery Day Year	
P.O.	Phys	9 Unknown	9 Unknown	Iting in the underly	vina causa aiven	in Part I	23e Did to	phacco use contribut	e to the cause of death?	
	2	at II. Other significant conditions contrib	uing to death but not resu	iting in the driderry	mig cause given	TILL CALLI.	1 🗆 1	0.52	Probably 4 Unknown	
or Vital Records,  Physician: The law requires tribis certificate has been signeral director, page 2 should be or	Completed						24a. Was	an 24b. Were	autopsy findings available to completion of cause of	
The law								rmed? death 2 No 1 □	1?	
Or Vital F Physician: Th this certificate	8	25. Was case referred to medical examiner?	ital:		Other	26. Place of Death				
On or ding Phys After this funeral dir	F	To res 20 No	8a. Date of Injury	28b. Time of	28c. Injury :	4 🗆 Nursing 11011		dence 6 Other (5	Specify)	
Vision Attending r death. ector: After	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury N	1 1 □ Ye	es 2 No				
Division  To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	<ol> <li>Place of injury - At hor building, etc. (Specify)</li> </ol>	me, farm, street, f	actory, office	2	8f. Location (8 City or Tov		r Rural Route Number,	
Hospita 24 hours Funera	Medical		on: To the best of my know On the basis of examinat and manner stated.	wledge, death occion and/or investi	urred at the time	e, date and place, a nion, death occurre	and due to the ed at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)	
To the To the To the Compi	Z	9			29c. License			29d. Date signed (M		
		Preet Bagi			1812	-8		JAN. 26	2008	
3		30. Name and address of person who comp PREET BAGI 22	eted cause of death (Item SOUTH GREE	NE STR	EET,	BALTIMO	RE, MA	RYLAND 3	21201	
5	State	AVEC 1	32. Registrar's Signat	ture	2.0					
DHMH 17 Re	y 1/200	JAN 6 3 ZUUC	Janes &	St Appe						
	00			ORIGI	NAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 27 onn 2008 49n4954 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOPKINS Bayyjew Baltimore Johns If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 10 M 2□F Months Days Hours MARYLAND 215-14-0345 86 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a State 10b. County or 28a-f show ir then "natural", or items 23a or 28a-f sho the Medical Examinar must be notified at 1 ☐ Yes 2 X No BALTIMORE DUNDALK Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 103 CENTRE PLACE APT. 112 21222 U.S.A. Funeral filed within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Xi Yes 2 No
If Yes, Give
Year or Dates: 942-45 Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 □ Divorced Š WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) SHEETMETAL MECHANIC BETHLEHEM STEEL other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Pages 1 and 2 should be is marksd FRANK WILLIS GLOSSNER ANNA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) If itsm 27 i JOHN D. WILLIS/ SON 740 WOODCREST WAY, MURRELLS INSLET, SC 29576 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXurial 2 Cremation 3 Removal from State permit. Page Depertment of Importsnt: If any Injury or ance. OAK LAWN CEMETERY 1/30/08 BALTIMORE, MARYLAND 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee LILLY & ZEILER INC. FUNERAL HOME 700 CONKLING STREET, BALTO., MD 21224 and the same Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner a donsequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as Examine burial-transit or Attending Physician: The law requires that the death certificete be executed sicien and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the ě IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown s been signed to should be dete 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available pnor to completion of cause of death? 24a. Was an page 2 s 2 No certificete 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medicai Certification: To 1 Yes 2 No this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. I Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours efter To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANTHONY HARRELL, M.D. 2112 DUNDALK AVENUE, DUNDALK, MARYLAND 21222

Date filed (Month, Day Year) 9 2008 32. Registrar's Signature

29c. License number

D0034

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

Barila

29b. Signature and title of certifier

noth

State Registrar

**Physician** 

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day William Dale Young 25, 2008 Sr. January 7:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 111 Compass Road Middle River Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | January 20,1925 5. Social Security Number 7. Age (In vrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 6. Sex 231-24-0613 1XM 2□ F Director 83 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits aţ notified 1 ☐ Yes 2 X No Directo Maryland Baltimore Middle River 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 111 Compass Road 21220 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
int: If item 27 Is marked other than "natural", or itee Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White þ 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates: Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland State Elementary/Secondary (0-12) College (1-4or 5+) Penitentiary 12 vears Correctional Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roby Matthew Young Mary Martin ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maxine Young wife 111 Compass Road, Middle River, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages Department of Important; If it any Injury or o January 1 Burial 2 Cremation 3 Removal from State Young's Chapel Cametery 29, 2008 4 Donation 5 Other (Specify) Mouth of Wilson, Virginia Signature of Funeral Service Lice see 22. Name and Address of Facility.
Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Firm End **Physician** Due to (or as a conservence of): disease or condition 112/2005 resulting in death) /Medical aeremovaso Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physician and for use as the burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. I ☐Yes 2☐No the detached 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ρ 1 | Yes 2 | No 3 | Probably 4 | Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has death? 1 □ Yes 2 □ No certificate 1∐ Yes or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: within 24 hours after area...

To the Funeral Director: After this completely filled in by the funeral dir P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide (s) and manner as stated. Medical 29a. Certifier

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

BARBARA G

(Check only one)

(COOK MI) 32. Registrar's Signature

and manner stated.

Campbell Blvd 21236

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Zabicki 2008 Mary В. January 26 3:25 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Aug. 6, 1922 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours 1 □ M 2 X F 85 345-14-9497 Illinois Director Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show Director Md. N/A 1 √Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 7203 Rockland Hills Dr. #407 21209 event, the Medical Examiner must Funeral USA 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married 1 □ Yes 2 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Budget Analyst Dept. of Navy I and 2 should be filed w lealth and Mental Hygie m 27 Is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Denis Bradley Mary Roche 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important; If item 27 is
any injury or other trau Mr. Steven Zabicki/ Husband 7203 Rockland Hills Dr. #407 Baltimore, Md. 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation Oueen Of Heaven Cem. 4 □ Donation 5 🛛 Other (Specifin tombment 2-1-08 Hillside, Ill. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
RUCK Towson Funeral Home,
1050 York Rd. Towson, Md. 23a. Part1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Dementin /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1☐ Yes 2 No Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o Q 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 autopsy performed director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 📉 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide

Ö ے Records, Vital Physiclan; 9 Hospital or Attending

MARY

21215-0036

Maryland

Baltimore,

PANDARC

10 State Registrar

MAHMOOD 31. Date filed (Month, Day, Year)

JAN 29

29b. Signature and title of certifier

29a. Certifier (Check only one)

> D 32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

2300 Dulaney Valley Rd. Trunoncom, Md 21093

To the

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Physician Year ICHARD RONG. Ol WU /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 6. Sen 1 M 2 □ F Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day. Year) Months Days Hours Min 173-26-5063 75 Director 08/03/1932 Pennsylvania Usual Residence of Decedent 10a. State show 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at 1 Yes 2 No Director 28a-f Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2643 Greenbriar Lane 21401 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 'natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ٥ 3 Widowed 4 Divorced Specify: White Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) the Capacity Planner IBM Department of Health and Mental Hygie Important: If Item 27 is marked other I any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental John Armstrong Mildred Oliver ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Stevens Armstrong/Wife 2643 Greenbriar Lane, Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 01/09/2008 | Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature Funeral Service Licenses Kales 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part I. En or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** w 50 /Medical Due to for as a consequence of) Examiner Recupro 6 CM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi TABETES Due to (or as a consequence of) physician Physician/Medical the IF FEMALE: for use If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2/No 1 🗌 Yes 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy certificate perform Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Pepatient Other: 4 Nursing Home 5 Residence 6 Other (Specity) 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending investigation Injury 2 Accident 1 Yes 2 No after death filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only

Division or Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier

Name and address of perso

441

who completed cause of death (Item 23a) (Type, Print)

JAN 1 0 2008

29c. License number

29d. Date signed (Month, Dav. Year)

D21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Z U U 8 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 16 10 PM 2008 JAN MARY AR BOGAST /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMOR5
If Under 1 Year If Under 24 Hrs.
Partie Days Hours Min. UNIVERSITY OF MARYLAND

5. Social Security Number | 6. Sex MEDICAL CENTER 8. Date of Birth (Month, Day, Year) April 25,1941 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** 1□M 2√2 F West Virginia 66 Director 233-66-7923 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h. County r 28a-f show notified at 1 X Yes 2 □ No Director Charles Indian Head Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 20640 U.S.A. 64 Circle Ave. "natural", or Items 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ▼No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Store clerk 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eleanora Hamrick Ralph Samples 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8204 Brooktree St., Laurel, Md. 20724 Cynthia J. Arbogast Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Jan. 8,2008 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Metropolitan Funeral Service 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service Licep M00668 20640 4270 Hawthorne Rd., Indian Head, Md. 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he thailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 45 HOURS HEMORRIHAGE INTEN CEREBRAL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Effect underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes HYPERTONSION Be Completed certificate has t rector, page 2 s

Division or Vital Records, P.O. Box 68760, thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu

				24a. Was an autopsy performed?  1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No	
25. Was case referred to medical			26. Place of De	ath Check onl one		
examiner? 1 ☐ Yes 2 No	Hospital: 1 Dipatient 2	ER/Outpatient 3 D	ome 5 ☐ Residence 6 ☐ Other (Specify)			
27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investiga		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	g Physician: To the best of my kn Examiner: On the basis of examin					

29c. License number

P19694

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. Dithmer - MO

University ab Maryland Medical Carder 22 South Greene St. Battimore MD 21201 31. Date filed (Month, Day, Year) JAN 1 4 2008

29b. Signature and title of cortific

Division or Vital Records, P.O. Box 68760.

State DHMH 17 Rev 1/2001

the

31. Date filed (Month, Day, Year) 1 4 2008 Registrar

(Check only one)

29b. Signature and title of certified

Chris Snyder,

P.R.M.C. 100 E. Carrollst. Salisbury, MD. 21822 32. Re strar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

29c. License number

H50497

29d. Date signed (Month, Day, Year)

10/0B

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Dorothy J. Burka 10, /Medical January 2008 7:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5802 Nicholson Ln, #506 <u>Rockville</u> Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🗓 F Director 578-20-4258 83 July 29, 1924 Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits a or 28a-f she t be notified a Director 1 ☐ Yes 2 ☐XNo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ral", or items 23a Examiner must b Completed by Funeral 5802 Nicholson Ln, #506 20852 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Cosmetics of Health and Mental Hygic I Item 27 is marked other I r other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Louis Jewler Sophie Snider 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Goldstein/Daughter 6529 Bradley Blvd, Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens Jan 13, 2008 Olney, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Glioblastoma Multiforme 8 mos /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 XNo Month 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2√ No 3 Probably 4 Unknown Completed 24a. Was an . Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performed: 1☐ Yes 2 💢 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760 after death Director: filled in by within 24 hours a To the Funeral L

DHMH 17 Rev 1/2001

Registrar

Medical

29a. Certifier

<u>Victor M. Priego, MD</u> 31. Date filed (Month, Day, Year) JAN 14 State 2008

29b. Signature and title of certifier

8420 Rockledge Dr, #4100, Bethesda, MD 20817

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D23308

29d. Date signed (Month, Day, Year)

January 11, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Stata Registrar	State of Marylan		artmen rtificate			Mental Hy	giene Reg. No	2000	02	164
	Dharaisi		1. Decedent's Name (First, Middle, Last)	)					2. Date of De	ath		3. Time o	f Death
	Physici /Medi		Jeanne Elizabeth H	Butts					January	7 15	2008	6:30	Ам
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or L	ocation of De	ath	4c	County of Deal	h	
			11907 Pheasant Trai			Hager					shingto		
	Funeral Director		5. Social Security Number 6. Second 10	TM 2FYE	last birthday) Yrs.	If Under Months	Days	If Under 24 H Hours Mi	n. (Month, Da	th ay, Year)	9. Birt	hplace (State ountry)	or Foreign
			216-30-3133 Usual Residence of Decedent	75					May 4	1932	2 Mar	yland	
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation						10d. Inside C	ity Limits
	B-f-e	io	Maryland Washington	n County   Hage	erstow	1						1 ☐ Yes	2 🗆 No
	or 28	Director	10e. Street and Number			10f. Zip	Code			10g. Cit	izen of What Co	ountry?	
	23a		11907 Pheasant Trai	i1		2174	12				U.S.A.		
	er der tems	une	17	<ol> <li>Was Decedent Ever in U. Armed Forces?</li> </ol>		Was Deced	ent of Hisp ify Cuban,	panic Origin? , Mexican, Pu	(Specify Yes or No erto Rican, etc.)	>-	14. Race - Ame Black, White		
36	s afte	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2	No 🖾	Specify:				hite	
8	within 72 hours after deeth with the Maryland ene. than "natural", or Items 23a or 28a-f ehow he Madical Examirer mat te notified at	ed b	15. Decedent's Edu	Year or Dates:	162 Door	dent's Usua	I Ossupati	ion		105 10			
15	n "na	Completed	(Specify only highest grade	o completed)	(Give	kind of wor DO NOT us	k done du	iring most of w	rorking	10D. K	ind of Business/	Industry	
212	d with	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Homema					Per	sonal R	esiden	ce
ਰੂ	al Hygorthe	Bec	17. Father's Name (First, Middle, Last)				1	8. Mother's N	ame (First, Middle	. Maiden	Sumame)		
<u>Ja</u>	uld b Ments urked utic e	2	Charles M. Hewitt					Edna Pa	arsons He	witt			
Maryland 21215-0036	2 sho and I is me		19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailir	ng Address	(Street an	d Number or i	Rural Route Numb	er, City o	r Town, State, 2	Zip Code)	
	and ealth m 27		Tanya Ridenour-daug					e. Hage	erstown,	MD 2	21742		
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show with injury or other traumatic event, the Maxical Examinat must be notified at once.		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ R		lace of Dispo emetery, crer	sition (Nam natory or ot	e of her place)		Date	20c. Lo	cation - City or	Town, State	
Ē	ment tant: jury		4 □ Donation 5 □ Other (Specify)	Res	t Have	en Cem	eter	y 1-18	3-2008	Наде	rstown.	Marylar	nd
Bai	Depar Impor Impor eny in		21. Signature of Funeral Service License	e / .	22	. Name and	Address	of Facility ]	Douglas A	. Fi	ery Fun	eral Ho	ome
	40200		Kaitly 3	Haron					. North H	-	stown,	MD 21/4	+2
			23a. Part1. Enter the disease, o complishock, or heart failure. List only on Immediate Cause (Final	cations that caused the death	. Do not ent				ac or respiratory a	rrest,		Approximat Interval Bet Onset and I	ween
	Physician /Medical		disease or condition resulting in death)	SRRA.	8.1	AN	Ce/2						
	Examiner			Due to (or as a consequ	ience of):								
		e.	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Que to (or as a cor sequ	iarioa ut):								
	cuted	Examiner	Cause (Disease or injury that initiated events										
ó	en ar en ar irial-ti	Ě	resulting in death) Last	Due to (or as a consequ	ence of):								-
8760,	The law requires that the death certificate be executed tie hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dical	d										
39	artifica ing pl	0	IF FEMALE:		-					- 1		100-00	
Вох	ath ce ttend or use	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar 1□Live birth 2□Fetal	death 3	Ectopic pre	gnancy				23d. Date of deli		,
0	thet the death certif ed by the attending detached for use as	Physician/M	1 Yes 2 No 9 Unknown	4☐Pregnant at time of de 9☐ Unknown	ath 5	Other (spe	cify)				Month	Day 1	Year
<u>.</u>	het the	4	Part II. Other significant conditions con	tributing to death but not recu	Iting is the w	dorking so		in Dead I	220 Dida			***************************************	
Records,	signed be del	1 by	Tarris Guide digital della communication com	mouning to death but not less	ning in the ui	idenying ca	use given	in ran i.			se contribute to	the cause of dobably 4 Dt	
Ö	w requir been si should	Completed							'U		2 3 □ Pro	bably 4 _C	Inknown
ě	hes hes ge 2 s	mp							24a. Was autor	sy	prior to c	topsy findings a ompletion of ca	available ause of
	(G CT			*					1 ☐ Yes	2 No	death?	2 A No	
VIta	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital:			104		eath Check only o	100			
Division of	ig Physical dispersal di	5. To	27. Manner of Death	1	R/Outpatien 28b. Time of		1	4   Nursing	Home 5 Resid		Other (Spec	ify)	
o	th. : After s tuner	흹	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м	c. Injury at Work?	s 2 □No		iott iiiqui,	, 55541154		
<u> S</u>	after death after death Director:	Hea	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor	ne, farm, stre	et, factory,			28f. Location (5	Street and	d Number or Ru	ral Route Num	ber.
ā	al or A s after al Dire	Certification:	4   Homicide	building, etc. (Specify,	,				City or Tov	vn, State,			
	Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the funer		29a. Certifier 1 Certifying Phys	ician: To the best of my know	vledge, death	occurred a	t the time,	date and place	ce, and due to the	cause(s)	and manner as	stated.	
	the H in 24 the Fi	Medical	one)	er: On the basis of examinati and manner stated.	on and/or inv	estigation, i	n my opin	ion, death occ	curred at the time,	date and	place, and due	to the cause(s)	1
	To the I	Σ	29b. Signature and title of certifier			29c.	License n	umber	,	29d. Day	signed (Month	, Day, Year)	
1	\$		1/1000		MI	)	174	2270	)	t/	16/68		
1	8			mpleted cause of death (Item					110 1 0	,87	• ^ ~	1100	
		1	31. Date filed (Month, Day, Year)		effers	m Bl	ND	Sm 17	us sury	L	y) (	1705	
	Star Registra			32. Regionari's Signati	N .	for #							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar			rtificate of			2008	02165
4	Physici		1. Decedent's Name (First, Middle, La					2. Date of Death Month	Day Year	NA
	/Medio		4a. Facility Name (If not institution, given	Barker ve street and number)	Ва	uchspies 4b. City, Town, or	Location of Death	anuary	12, 2008 4c. County of Dea	1:20A <sup>™</sup>
450		Н	6422 Sunset Driv	-		Freder			Frederic	
ш	Funeral Director			Sex 7. Age (In yrs. 1 1 ☐ M 2 <b>X</b> F <b>74</b>	ast birthday Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day, )		rthplace (State or Foreign country)
7			Usual Residence of Decedent  10a, State 10b, County	100 Cit	, Town or L	onation	1	anuary 2	25,1933 1	
a /vi a	f shovied at	jo]	10a. State 10b. County  Maryland Frederi			derick				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
4	or 28a- e notif	irec	10e. Street and Number			10f. Zip Code		100	g. Citizen of What C	ountry?
d 21215-0036 filed within 72 hours after death with the Manuland	"natural", or items 23a or 28a-f show edical Examiner must be notified at	Funeral Directo	6422 Sunset Drive			2170			USA	
ther de	r items	Fune	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces?  1 ☐ Yes 2 ☑ No	S. 13.		ispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Am Black, Whi	
215-0036	rai", o Exam	by	3 ☐ Widowed 4 ☐ Divorced	1 Tyes 2 No If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:		Specify: W	nite
ליל הל הלילו	giene. rr than "natu the Medical	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	edent's Usual Occup	ation during most of working f)	7 16	Bb. Kind of Business Water Tre	:/Industry atment
7 L Z	jiene. r than the M	omo	Elementary/Secondary (0-12)	College (1-4or 5+)			rvice Rep.		Busine	
ind be filed		BeC	17. Father's Name (First, Middle, Last Richard W.				18. Mother's Name (	First, Middle, Ma		
Maryland d2 should be file		٦			405 14-11		Grace		Strite	
Mai	f Health and Mer ftem 27 is marke other traumatic	r j	Judy England/Daug		I		Road, Mt.	•		Zip Code)
ore,	of Hea		20a. Method of Disposition	20b. P	ace of Disp	osition (Name of ematory or other place	Da		Oc. Location - City of	r Town, State
Saltimore,	tment tant: It jury o		PD Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	JHemoval from State	ing Cı	eek Pres	Cm 1/18 /	2008 S	tate Coll	lege, PA
	Department of Important: If it any injury or o		21. Signature of Funeral Service Lice	perce Q	2	2. Name and Addres	ss of Facility Star	uffer Fu	neral Hon	ie, PA
			23a. Part1. Inter the disease, or com	pplications that caused the death			g, such as cardiac or			Approximate Interval Between
PI	hysician		shock, or heart failure. List only Immediate Cause (Final disease or condition	ANENO CARC	INOMI	A EF UN	KNOWN 1	RIMA	Ry	Onset and Death
	Medical xaminer		resulting in death)	Due to (or as a consequ					1	7 7 1 62 7 7
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	ence of):					
cuted	nd ransit	Examiner	that initiated events	C						
oC,	cian a	EX	resulting in death) Last	Due to (or as a consequ	ence of):				•	
os/ou, rtificate be executed	ig physician and as the burial-transit	Medical		_d						
	ending use a	In/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal		∃Ectopic pregnancy			23d. Date of de	elivery
e deat	the att	hysician/N	in the past 12 months? 1 □ Yes 2!54No 9 □ Unknown	4☐Pregnant at time of de		Other (specify)			Month	Day Year
ecords, F.O. box	certificate has been signed by the attendin rector, page 2 should be detached for use	Δ.	Part II. Other significant conditions	contributing to death but not resu	Iting in the u	inderlying cause give	en in Part I.	23e. Did toba	cco use contribute t	to the cause of death?
COLOS, w requires	n sign	d by						1/X Yes		robably 4 □Unknown
ecco law re	2 shor	Completed						24a. Was an	24b. Were a	utopsy findings available
r e	cate h	Com						autopsy performe 1□ Yes 2	ed? death?	completion of cause of s 2 □ No
VII.all	certifi	Be	25. Was case referred to medical examiner?	Hospital:		ot 3 DOA Othe	26. Place of Death (			
בולה בולה	er this eral di	ان ان	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time o	IL 3 DOA	4 LI Nursing Home	e 5 Residend d. Describe how	ce 6 □Other (Spe injury occurred	eify)
SIOT	or: Aft he fun	atio	1 Accident  5 Pending investigation		Injury	l l	Yes 2 □ No			
JIVII.	Direct Direct in by t	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		me, farm, st	reet, factory, office	28	f. Location (Stree City or Town,	et and Number or R State)	lural Route Number,
DIVISION OF VICE To the Hospital or Attending Physician:	within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 12 Certifying Pt	nysician: To the best of my know	vledge, deat	h occurred at the tim	ne, date and place, an	nd due to the cau	se(s) and manner a	s stated.
he Ho	in 24 h	Medical	Check only 2   Medical Exal	miner: On the basis of examinat	ion and/or in	ivestigation, in my oi	pinion, death occurred	tat the time date	e and place, and du	e to the cause(s)
Tot	To 1	Σ	29b. Signature and title of certifier	Par 1	20	29c. License	21.76.1	29d	. Date signed (Mon	th, Day, Year)
		-	30 Namo and address of names	completed cause of death (i)	220) (T	Print)	31 /0/		11141	0
V	Q		29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who  BUAN 162  JAN 162	CONVER ML	23a) (Type,	12, SEL	SUH SI	. FRE	ERICK 1	42 21781
9	Sta	te	31. Date filed (Month, Day, Year)	32. Degistrar's Signat	ure	nate		/	1	
	Registr	MF.	JAN 1 6 2	UUO DELLE S	1 19					

			For State of Mai	ryland / [	Department of I Certificate of		<i>l</i> lental Hy	20/	10 02166
	2hvolei	2.5	1. Decedent's Name (First, Middle, Last)			Douili	2. Date of De	_	3. Time of Death
	Physici Medio/	cal	Mary Lou Brezina				January	y 10 200	
	Examir	ier	4a. Facility Name (If not institution, give street and number) 3222 Brezina Place		4b. City, Town, c	or Location of Death		4c. County of	
F	uneral		5. Social Security Number 6. Sex 7. Age	(In yrs. last bir	thday) If Under 1 Year Months Days		8. Date of Bir (Month, Da	Anne Ai	Birthplace (State or Foreign Country)
	rector		Usual Residence of Decedent	73	Yrs.	110010	09/26/1	1934 Wa	ashington, D.C.
yland	at		10a. State 10b. County	10c. City, Towr	n or Location				10d. Inside City Limits
не Ма	8a-f s	ctor		Edgewat	ter				1 □ Yes 2 No
with th	a or 2	Dire	10e. Street and Number 3222 Brezina Place		10f. Zip Code 21037			10g. Citizen of Wha	•
death	in of freat and weather righten.  The man are weath, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	Funeral Director	11 Marital Status 12 Was Decedant Ev	ver in U.S.	13. Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No	United St	American Indian,
I all y lating KIKI 5-0050 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.	, or ite	by Fu	Armed Forces?  1 Never Married 2 Married   1 Yes 2 No.	5	1 ☐ Yes 2X No	Specify:	Hican, etc.)	Specify:	White, etc.
S hours	atural' cal Ex		3 ☐ Widowed 4 ☐ Divorced Year or Dates:	16a.	Decedent's Usual Occup	pation		16b. Kind of Busir	White Dess/Industry
thin 72	an "na Medic	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	- //	(Give kind of work done life. DO NOT use retire	during most of work	king		io do in idudity
led wi	her th nt, the		17. Father's Name ( <i>First, Middle, Last</i> )	Ноп	nemaker	40 Matter & Ma	(F) (A) (W)	Home	
d be fi	c ever	o Be	Michael Alexander Moltz			_		, Maiden Surname)	
al y	s marl	٦	19a. Informant's Name/Relationship (Type. Print)	19b.	. Mailing Address (Street	Carrie V			ate, Zip Code)
and 2	m 27 i her tra		George L. Brezina/Husband		222 Brezina				
Pages 1 and 2	if ite		20a. Method of Disposition 1 ☐ Burial 2 🗖 Cremation 3 ☐ Removal from State	cemeter	Disposition (Name of ry, crematory or other pla	ce)	Date	20c. Location - Cit	
permit. Page Department of	Important: If item 27 any Injury or other tr once,		4 □ Donation 5 □ Other (Specify)  21. Signature of Type at Service Licensee	Katas	Crematory  22. Name and Addre		/2008	Edgewater	, Maryland
Deg a	any Ir		* Millel		2973 Solom	ons Islan	d Rd.,E	dgewater.	MD 21037
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	he death. Do n					Approximate Interval Between
	sician edical		resulting in death)		leart Fail	ure			Onset and Death
	miner		Due to (Vas a	consequence	Disease				
P P	#	iner	Sequentially list conditions, if any, leading to fininediate cause. Enter Underlying Cause (Disease or injury	Consequence v					
recute	and I-trans	Examiner	resulting in death) Leet	rtens consequence of	sion .	<del> </del>			
S e e	physiclan and the burial-transit	calE	d	oonsoquonos c	51).				
rtificat	ng phy as the	Medical	IS SERVALE.		-				
The law requires that the death certificate be executed	attending for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf	Fetal death		<i>y</i>		23d. Date o	
the de	signed by the a	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at til 9 ☐ Unknown 9 ☐ Unknown	me of death	5 ☐ Other (specify) _			World	Day Tear
s that	gned b	by Pr	Part II. Other significant conditions contributing to death but	not resulting in	the underlying cause giv	en in Part I.	23e. Did to	obacco use contribu	ite to the cause of death?
equire	should b		Endstage renal disease	after	venal	tranplan	10	Yes 2 1 No 3[	☐ Probably 4 ☐ Unknown
e law i	8 2	Completed	Hypothyroidism				24a. Was autor	osv prio	re autopsy findings available r to completion of cause of
	ate oag		Transplant nephropathy 25. Was case referred to medical				1 Yes		th? Yes 2 □ No
ysicia	this certifica al director, p	To Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient	t 2 ER/Out	tpatient 3 DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho			(Specify)
<b>-</b> 51	je je		27. Mann of Death 28a. Date of Injury 1 atural 5 Pending (Month, Day )		ime of 28c. Injury Wor			how injury occurred	Оросину
ttendi death.	ctor: /	icati	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of injury	v - At home, far	M 1 □	Yes 2 □ No	206 Location (6	Change and Alexandra	or Rural Route Number,
alor A	d in b	Certification:	4 Homicide determined building, etc.		m, succe, ractory, omce		City or Tov	vn, State)	or murar moute Nurriber,
To the Hospital or Attendin within 24 hours after death.	unera ely fille		29a. Certifier (Chack only and care) 12 Certifying Physician: To the best of examiner: On the basis of examiner:	my knowledge	, death occurred at the til	me, date and place,	and due to the	cause(s) and manne	er as stated.
thin 24	the F	Medical	one) and manner state 29b, Signature and title of certifier	ed.	29c. Licens				
ĭ ≥ i		$\frac{1}{2}$	I former for The			62705		29d. Date signed (A	
Gar.	S		30. Name and address of person who completed cause of dear	ath (Item 23a) (		+ 5.70		J1-10- 8	8
1	NA		Lucinda L. Mundorf M.D. 116	Defense	e Hwy.,Suite	400, Anr	napolis,	, Maryland	1 21401
	Sta Registra		31. Date filed (Month Pay, Year) 2008 33 Registrar's	S Signature .	beck				

08-00342 Hilda Carmen Cru	~	Please Type or Print in					e.		
milida Carmen Cri		State of Maryla - For State	and / Department of Certificate of		іепіаі пудіє		200	8 0215	
Physicia		eqistrar . Decedent's Name (First, Middle,Last)				Reg. No ate of Death		3. Time of Death	
Medical Examin		Hilda Del Carmo	en Cruz		Ja	lonth Day Inuary 12, 20	Year 008	0742 hrs	
F3		a. Facility Name (if not institution, give street and nu		4b. City, Town, or Loca	tion of Death		c. County of Death		
		Prince Georges Hospital Center		Cheverly			Prince George's		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)				M/DD/YYYY) 9. Birth	El Salvado	
Director		none	26 <sub>Y</sub>	rs. Months Bays	100.73	Tan.28,	1981 Cou	ntry)	
Š.	L .	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits	
ow any	- [	MD Prince George						1 Yes 2 XNo	
yland a-f sh	흵	De. Street and Number		10f. Zip Code		10g. C	itizen of What Count	ry?	
e Mai or 28	Director		T-2	2071	0	El	Salvado	r	
vith th			cedent Ever in U.S. 13. V	Was Decedent of Hispani	c Origin? ( Specify	Yes or No-			
eath v item	Funeral	1 Never Married 2 XMarried Armed F	orces?	f Yes, specify Cuban, Me EI Sa.	vican, Puerto Rica Lvadore	n, etc.) <b>n</b>	White, etc.	White	
ifter d		3 Widowed 4 Divorced If Yes, Give Yes		X Yes 2 No sp			Specify:		
ours a	Completed by	15. Decedent's Education (Specify only highest grades)	during	dent's Usual Occupation ( most of working life, DO		done 16b	. Kind of Business/In	dustry	
6 n 72 h an "n ical E	Set	Elementary/Secondary (0-12) College (	1_1 or 5+\	aning	, , , , , , , , , , , , , , , , , , , ,		Cleaning	Co.	
within speed of Med	E I	17. Father's Name (First, Middle, Last)		18.0	Name (First	t Middle Maide	en Surname)		
filed all Hyge ed off	Be C	Miguel Angel Cruz					en Colat	.0	
212 uld be Ments mark	립	19a. Informant's Name/Relationship (Type, Print )	ughand / 19b. Mai	ling Address (Street and					
AD 2 sho h and h and 127 is		Cipriano Hernandez	Saravia 42	33 58th A	venue #				
Ge, Land I and Healt Healt Fittem	ı	20a. Method of Disposition  1 X Burial 2 Cremation 3 X Removal for	20b. Place of Disp	position (Name of cemete	ry, Da	te 200	binameca	own, State L, SanMigue	
MOI Pages ent of int: 1		4 Donation 5 Other Specify:	TOTA State	El Manzan	o 1/19	/2008	El Salv	ador	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show, injury or other traumatic event, the Medical Examiner must be notified at once.	-	21. Signature of Funeral Service Licensee	33	Name and Address of FHILIP D.R. 241 Colum	ÎNALDI	FUNERA	L SERVIC	E,P.A.	
		Mey chill	9	241 Colum	<u>bia Blv</u>	d.Silv	er Sprin	Approximate Interval	
Physician /Medical		23a. Part I. Enter the disease, or complications that of failure. List only one cause on each line.		er the mode of dying, such	n as cardiac or res	piratory arrest, s	HOCK, OF HEAR	Between Onset and Death	
aminer		Immediate Cause (Final disease a. Hemoperitor condition resulting in death)	oneum a consequence of):					Death	
*		h Ruptured F	Pancreatic Pseudocys	t					
	ē		a consequence of):						
h	Examiner	(Disease or injury that initiated	ancreatitis a consequence of):						
executed ian and ial - transit	Δĺ	d							
e exec	dical	UNPENDED AMENDED							
760 cate b	sician/Med	Oh 184 and does does does a second in the	outcome of pregnancy			- 2	23d. Date of delivery		
68 certifi nding	ian	3b. Was decedent pregnant in the past 12 months?	birth 2 nant at time of death 5		Ectopic pregnancy		Month D	ay Year	
Box 68760, he death certificate be the attending physicined for use as the burined for use	ysic	1 Yes 2 No 9 V Unknown g Unkn	3	Other (Specify)					
O. E	Phy	Part II. Other significant conditions contributing t		he cause of death?					
ires that the signed by the detache	d b	Obesity		1 Yes 2 No 3 Probably 4 Unkno					
ords, w requir	lete					24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of	
ecc he fav ate has	ompleted					performed 1 ✓ Yes 2		s 2 No	
Vital Reco ysician: The law his certificate has director, page 2 s	Be C	25. Was case referred to medical			Death (Check only	one)			
Vita hysici this c	고	examiner?  1  Yes 2 No Hospital: 1	Inpatient 2 ER/Outpati				idence 6 Other	:	
n of VI; Jing Physi  After this funeral dir			e of Injury th, Day,Year)		t Work? 28c	d. Describe how	injury occurred		
SiOr Attend death ctor:	atic	2 Accident Investigation				Leasting (Street	at and Number of Du	ral Route Number, City	
Division of Vital Records, P.O tal or Attending Physician: The law requires that its after death.  al Director: After this certificate has been signed be led in by the funeral director, page 2 should be detaged.	Certification:	Suicide Could not be determined (Specific	ce of Injury - At home, farm, s	street, factory, office build	ing, etc. 261	or Town, State		rai Notice Number, Oity	
Cospite Hours unera		4 Homicide  29a. Certifier A Continue Physician To the be		curred at the time, date a	and place, and due	to the cause(s)	and manner as state	ed.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be deached for use as the built	Medical	one) 2 Medical Examiner: On the basis	of examination and/or investi	igation, in my opinion, de	ath occurred at the	e time, date and	place, and due to the	e cause(s)	
To Wit	Mec	29b. Signature and title of certifier	sigieu	29c. License nu	ımber	29	d. Date signed (Mor	nth, Day, Year)	
2		/ as bake us	)	O.C.M.E	Ξ.	Ja	anuary 13, 2008	3	
12.	4	30. Name and address of person who completed cau							
		Laron Locke MD. Assistant Medica	<u></u>	enn Street, Baltimor	re, MD 21201				
Sta Regist	ate	31. Date filed (Manth Pay, Year 4 2008 32.	egistrar's Signature	backer					
DHMH 17 Rev 1/20		1/-	ORIGIN	NAI					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 BARBARA GEORGE CHACONAS JANUARY 9  $A^{M}$ 5:38 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NATIONAL INSTITUTES OF HEALTH **BETHESDA** MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 217-02-5084 59 15, Feb. Greece Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Montgomery Wheaton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 11608 Georgia Avenue 20902 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2√E No Specify: Speciwhite 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Dounias Georgia Papadakos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George C. Chaconas/Husband 11608 Georgia Avenue, Wheaton, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Metropolitan Crematory 20 4 □ Donation 5 □ Other (Specify) 2008 Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee Kens 500 University Blvd, W., Silver Spring, MD 20901 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VASCULAR disease or condition resulting in death) enclosiAl hours Due to (or as a consequence of): aTMIAI days Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or às à consequence ot): Dilated Due to (or as a consequence of) Rheumatic IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ YNo 9□Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? phoblA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No autopsy performed? 1 Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

**Physician** /Medical Examiner

and

nding physician

Physician

/Medical

Examiner

Director

Be Completed by Funeral

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be accessed.

Baltimore, Maryland 21215-0036

Examiner by Physician/Medical Completed Be Certification: To

or Attending Physician: The law requires that the death certificate be executed

After

within 24 hours at To the Funeral D To the Hospital

Division or Vital Records, P.O. Box 68760,

burial-transit signed by the a s after deau...

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Minpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 | Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

D0048201 MD

29d. Date signed (Month, Day, Year)

State Registrar

Medical

31. Date filed (Month, Day, Year) 1 4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Month Jai 2008 MARGARITE V. COPELAND /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Harger Health Kehab. 01 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F Yrs. 218-28-2630 88 Director MARYLAND JUNE 20, 1919 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 ▼Yes 2 No Director MARYLAND HARFORD BEL ATR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 700 SELKIRK COURT 21015 USA Funeral Pages 1 and 2 should be filed within 72 hours after death . Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Mamed Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 X No Specify Specify: BLACK þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Item 27 Is marked other than LICENSED PRACTICAL NURSE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RANDOLPH HOWARD STEWART DAISEY JULIA BRADFORD 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAURA M. COPELAND / DAUGHTER 700 SELKIRK COURT, BEL AIR, MARYLAND 21015 IN LAW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) CLARKS UNITED METH CEM 1/16/08 BEL AIR, MARYLAND 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee Josth 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially flet donulitors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of) vision or Vital Records, P.O. Box 68760 physician death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) by the a 9 Unknown The law requires that the 9 Unknown by det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 1100 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performe page certificate 1 ☐ Yes or Attending Physician: rector, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 <u>No</u> 1 Yes 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Marrier of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation (Month, Day Year) Natural within 24 hours and comments to the Funeral Director: Af 1 □ Yes 2 □ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

0

30. Name and address of person who com-

Year

2008

31. Date filed (Month, Day,

JAN 15

Margaril

eath (Item 23a) (Type, Print)

32. Registrar's Signature

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3. Time of Death

3 Date of Death

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. att if them 27 is marked other than "natural", or items 23a or 28a-f show "natural", or Iten Baltimore, Maryland 21215-0036 7 is marked other than "natu traumatic event, the Medical 1. Decedent's Name (First, Middle, Last)

**Physician** /Medical Examiner

Division or Vital Records, P.O. Box 68760,

2008 **Physician** 6:15 January ам Elizabeth S. Clopper /Medical 4a. Facility Name (If not institution, give street and number) Ctr 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Lutheran Village Health Care Carroll Westminster 8. Date of Birth (Month, Day, Year) Oct 02 1917 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 90 225-32-0067 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits MD Items 23a or 28a-f sh ner must be notified Carroll Westminster 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 205 St. Mark Way USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 █**\**No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 █No Specify: Specify: White ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 4 + Elementary/Secondary (0-12) Librarian Board of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LeRoy Ross Summers Lucy Cynthia Roop 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1511 Dulany Road Finksburg, MD 21048 Susan Schubert/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages
Department of
Important: If it
any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/15/2008 4 ☐ Donation 5 ☐ Other (Specify) Oakwood Cemetery Pulaski, Va 21. Signature of Funeral Service Licenses Pritts Funerally Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCUP Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Physician/Medical attending ph IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Devus 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed?
1☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 27 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) er: On the basis of examination and manner stated. within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Jan 11th 2008 WJL 30. Name and address pleted cause of (Item 23a) (Type, Print) 10 2 horus here Sub 10201 wester Alexander Boarlash Registrar Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Year LaDorne Dietle  $\mathbf{a}^{\,M}$ 12, 2008 January 6:56 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Min Director 577-34-2214 81 1926 Washington, Nov. 29, Usual Residence of Decedent 10a, State 10c. City, Town or Location show 10h. County 10d. Inside City Limits r 28a-f show 1 □Yes 2√□No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? th and Mental Hygiene. 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 206 Plymouth Street 20901 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: SpecifWhite þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Entrepreneur Restaurant 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Augustus Leonard Olive Jordan ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele D. Snow/Daughter 14313 Astrodome Drive, Silver Spring, MD 20906 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Jan. 13 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Kehard I Heles 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

MD 20001

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Acute Myocardial Infarction days /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Due to (crase a corresquence of): Sequentially list conditions, vears Examiner If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed burial-trai Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached i Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 24a. Was an autopsy performed' certificate 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 Hnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 ☐ Pending investigation 1x Natural Injury safter ob... ral Director: Am to the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Medical 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner state To the I within 24 29b. Signature and title off certifier 29c. License number 29d. Date signed (Mogth, Day, Year) 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20407 Seneca Meadows. Germantown, MD 20876 Jose de Leon Carpio, MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN

1 4 2008

32 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of	f Mar	yland /		artment of rtificate of			lental Hy	gien	е		
of a		JAN Y	Registrar  1. Decedent's Name (First, III	Middle, Last	······			Cei	uncate of	Deat	n	2. Date of De	Reg. No	2008	3-1	2 172
	Physici		Maria So			)						Month January	Da	ay Yea 8 200		6:15 p <sub>M</sub>
	/Medi Examir		4a. Facility Name (If not insti				er) 4b. City, Town, or Location of Death						4c. Coun			
1				ood Man						illers				Anne	e Arund	le1
5	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 ☒ F			7. Age (In yrs. last birthday) 83 Yrs.			If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.			8. Date of Birth (Month, Day, Year) December 12,192		7001	9. Birthplace (State or Foreign Country) Philippines	
	land ow		Usual Residence of Deceder 10a. State 10b. Co			10	0c. City, To	own or Lo	cation						10d. Ins	ide City Limits
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	or 28; e not	Director	10e. Street and Number						10f. Zip Code				10g. Ci	itizen of What (	ountry?	
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396	d within 72 hours after death with the Maryland giene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □  3 ☑ Widowed 4 □ Divo	Married	12. Was Dece Armed For 1 ☐ Yes If Yes, Giv Year or Da	rces? 2⊠No ⁄e	er in U.S.	Į.	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No			ecify Yes or No Rican, etc.)	0-	14. Race - An Black, Wh Specify:		
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Maryland 21215-0036	d within giene. r than "	Completed	Elementary/Secondary (0- 10	12)	College (1	-4or 5+)		life. I	DO NOT use retir		OSI OI WOIKI	y		Pr	Private	
and		Be	17. Father's Name (First, Middle, Last) 18. Mother's N									,	n Surname)			
Σ̈́	2 should be and Menta is marked raumatic ev	ပ	Simplicion 19a. Informant's Name/Rela				1	Ob Mailir	ng Address (Stree	t and Nun		bia Wativ		or Town Ctate	7:- O- d- \	
	nd 2 s ulth an 27 is i		Dan De Castro				'		Daisey Cr							
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<u>E</u>	Pages ment of l ant: If ite ury or o		1 X Burial 2 ☐ Cremate 4 ☐ Donation 5 ☐ Oth			State			ington Ce	1	01/13	1/2008	Ade	lphi, Mai	yland	
Baltimore,	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Ser	vio License	"Wins	16	71	H	Name and Add lines-Rina 1800 New 1	ldi Fu	neral H	Home, Inc	Lver	Spring, N	Marylan	d 20904
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between													al Between
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	/Medical Examiner		roodiling in dealify		Due to (	or as a co	onsequenc	e of);								
3.		er	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	or as a c	a consequence of):											
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90,	ificate be executed physician and is the burial-transit	EX	resulting in death) Last		Due to (d	or as a co	onsequenc	e of):								
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P.O. Box (	ath certi attending for use a	Physician/Me											23d. Date of delivery Month Day Year		Year	
	that the de ned by the a detached i										t I.	23e. Did t	23e. Did tobacco use contribute to the cause of death?			
rds	w requires that been signed b should be deta	ed by						_				10	Yes 2	No 3□ F	robably	4 □Unknown
900	e law re has bed je 2 sho	Completed										24a. Was		24b. Were a	autopsy finc	fings available n of cause of
<u>د</u> ۳		Com										perfo	ormed?	death?	,	
Zit'	siclan: Th certificate rector, pag	Be	25. Was case referred to me examiner?		Hospital:				To	la a u		Check only				
ō	Phys or this eral dis	2	1 ☐ Yes 2 ☐ No 27. Manner of Death		1 ☐ In	<u> </u>	2   ER/0	Outpatien  Time of	t 3 DOA 28c. Inju	414		me 5 Resi		6 ☐Other (Sp	ecify)	
on	nding f ath. r: After e funer	atior	1 Natural 5 ☐ Pe 2 ☐ Accident inv	ending restigation	(Month	h, Day Ye	ear)	Injury		ork? ]Yes 2[	1			.,,		
Division or Vital Records,	al or Atte s after des Il Directo ed in by th	Certification:		ould not be termined	28e. Place of building	of injury -	At home, Specify)	farm, stre	eet, factory, office	1-11		28f. Location ( City or To		nd Number or F e)	?ural Route	Number,
	or the Hospital or Attending Physician: within 24 hours after death to the Funeral Director: After this certifica completely filled in by the funeral director,	Medical (	29a, Certifier 1X Cert (Check only one) 2 Med	ifying Phys ical Examir	ner: On the ba	asis of exa er stated	amination a	and/or inv	occurred at the vestigation, in my	opinion, d	leath occurr	ed at the time,	date an	d place, and du	ue to the car	
	Within For	Σ	29b. Signature and title of ce	rtifier /	1.	11	~		29c. Licen	se numbe	r		29d. Da	ate signed (Mor	ith, Day, Ye	ear)
)	$\nu$		· On	(1	, was	20	(1)	)	_ D	3113	6		JA	NUAR	49,	2008
			30. Name and address of per	C.	mpleted cause	of death	(Item 23a	(Type, F	005 1	-(11	3RiD	OF RE	1, 8	AUTM	ore, n	2008 2008 321236
-	Sta Registr		31. Date filed (Month, Day, Y	4 200	8	yısırar's	Signature	do	wei )				,		,	

WIL 4+4

DHMH 17 Rev 1/2001

State Registrar address of person who completed cause of death (beth 23a) (Type Print)
i J. Swreja M.D. 4212 Ridge Rd, Westminster Md. 2115.7 32. Registrar's Signature

**JAN 10** 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

State

Hemen

31. Date filed (Month, Day, Year)

shal

JAN 1 6 2008

65 c Thomas

32. Registrar's Signature

Frederick

DY

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State	of Marylan	•	artment rtificate				F	Reg. No.	008	021	75	
	Physici	an	1. Decedent's Name (First, Middle, L.								2. Date of Dea Month	Day	2 0 O Year	3. Time of		
	/Medic		Tandary										10, 2008 8:45 PM			
	Examin	er	4a. Facility Name (If not institution, gi Frederick Memoria			rick	or Death			Frederick						
	Funeral			Sex	7. Age (In yrs. last birthday) If Under 1 Year If Under						8. Date of Birt	h Vaar	9. Bir	thplace (State or	r Foreign	
	Director		198-03-3662	1 <b>☆</b> M 2□F	92	Yrs.	Months	Days	Hours	Min.	Dec. 26	, 1915	9. Birthplace (State Country) 1915 Pennsylva			
	pu k		Usuel Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation					10d Ins			ty Limits	
	Maryla r eho										1 ☐ Yes 2 ☒ No					
	28s-1	Director	10e. Street and Number		10f. Zip	Code			10g. Citizer	0g. Citizen of What Country?						
	3a or		7144 Poole Jones	Road				2170	2		Unit	ted St	ates			
	deeti	Funeral	11. Marital Status	12. Was De	ecedent Ever in U. Forces?	.S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	. 14.	Race - Ame Black, Whit	nerican Indian,		
36	a within 72 hours after deeth with the Maryland Jiene. r then "natural", or itams 23s or 28s-1 ehow the Medical Exaction must be rediffed at	y Fu	1 Never Married 2 Married	1.⊠Yes	12⊠Yes 2 □ No If Yes, Give WWII 1			25 No	Specify:		, , , , , , ,			White		
Ö	hours turni',	d by	3 Widowed 4 ☐ Divorced  15. Decedent's B	Year or Dates:								16b. Kind of Business/Industry				
75	in 72 n "nai	Completed	(Specify only highest g	ade completed)			ecedent's Usual Occupation five kind of work done during most of working e. DO NOT use retired)					iod. Nind of Eddingsam ducky				
212	D 50 5 20	E O	Elementary/Secondary (0-12)	College	(1-4or 5+)	Waite	r/Bar	tend					Restau			
D	be filed ite! Hygid of other event, t	Bec	17. Father's Name (First, Middle, Las	t)							(First, Middle,	Maiden Su	mame) (U	ınk.)		
yla		2	James DiAngelis						Anto:							
Maryland 21215-0036	s 1 end 2 should f Heelth and Mer item 27 ie marke other treumatic		19a. Informant's Name/Relationship		1						Route Numbe	-				
	s 1 end 2 of Heelth a item 27 is other tree		Antoinette Smith 20a. Method of Disposition	/ Daug	20b. F	Place of Dispo	sition (Nan	ne of			ederic			Town, State		
Baltimore,			1 ☐ Burial 2 X Cremation 3		m State	semetery, crei sthave:				an. 200				Marylan	d	
İĦ	permit. Page Depertment of importent: if eny injury or once.		4 □Donation 5 □ Other (Special Signature of Funeral Service Local Control of Service Local Cont								rvices					
Ba	permit. Depertrimporte eny injource		1/1//			95	stnav 01 Ca	ren 1 Itoct	unera in M	aı Se tn. H	rvices Wy. Fr	, skko ederio	ck, M	21701		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Bety		
	Physician		Immediate Cause (Final disease or condition Sepsis										Onset and D	<i>J</i> eath		
	/Medical Examiner		resulting in death)	Due 1	to (or as a conseq							_				
н	Examiner	_	Sequentially list conditions,		e Renal		e							Days		
	led isit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	to (or as a conseq	derice or).										
	i be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due t	to (or as a conseq	uence of):										
760,	an 5. 00	cal		d												
9	eath certificat ettending phy I for use as thi															
Вох	death certifica a ettending ph d for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		Ectopic pr	egnancy				230	d. Date of de Month	,	rear	
	0 46 5	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□ Pre 9□ Uni	ignant at time of d known	eath 5	Other (sp	ecity)					Wichill		541	
P.0	The law requires thet the tab been signed by the bage 2 should be detache		Part II. Other significant conditions	contributing to	death but not res	ulting in the u	ndertvina c	ause dive	en in Part I		23e. Did to	obacco use	contribute t	o the cause of d	leath?	
ds,	signe d be c	d by	Turni onto a gini a a a a a a a a a a a a a a a a a a			ag a		g			101	res 2000.	√o 3 🗆 P	robably 4 🗆	Jnknown	
Sor	w requir been si should	ete									24a. Was	an 2	24b. Were a	utopsy findings a	available	
Vital Records,	The lay	Completed									autop perfo	rmed?	prior to death? 1 ☐ Yes	completion of ca	ause of	
ta		0	25. Was case referred to medical				-		26. Place	of Death	(Check only o		1016	2 2 140		
<u></u>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2⊠XNo	Hospital: 1 (	Inpatient 2 □	ER/Outpatier	nt 3 DC	Oth	er: 4 □ Nu	ursing Hon	ne 5□Resid	dence 6	]Other (Spe	ecify)		
n of	5 5 E		27. Manner of Death 1   Natural 5 □ Pending	28a. Da (M	te of Injury onth, Day Year)	28b. Time o Injury		8c. Injury Work			28d. Describe h	now injury o	ccurred			
sio	Attending r death. sctor: After by the fune	cati	2 Accident investigati 3 Suicide 6 Could not	he			М		Yes 2 🗆		104 Leasting /	Stract and A	Jumbar or C	Dura I Clauda Alica	has	
Division	or At after of Direct in by	Certification:	4 Homicide determine	d 286. Pla	ice of Injury - At he ilding, etc. (Specif	ome, tarm, sti y)	eet, factory	, oπice			City or Tov		iumber or A	lural Route Num	Der,	
_	To the Hospitel or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 X Certifying F	hysician: Fo	the best of my kno	wledge, deat	h occurred	at the tin	ne, date an	nd place, a	and due to the	cause(s) an	id manner a	s stated.		
	1 24 h	edical	(Check only 2 Medical Extended)		basis of examina anner stated.	ition and/or in	vestigation,	, in <i>m</i> y o	oinion, dea	th occurre	ed at the time,	date and pl	ace, and du	e to the cause(s	)	
	To th withir To th comp	×	29b. Signature and title of certifier		)				number		1		_	th, Day, Year)		
)	Sam		•	1			D	4309	<del></del>			Janua	ry II,	, 2008		
7	7/11		30. Name and address of person wh		-		-			100 (	01701					
,			Saeed Zaidi, M.D  31. Date filed (Month, Day, Year)	. 801	Toll Hou	ise Ave	F1	cede	rick,	MD 2	21/01					
	Sta Registr		JAN 1 6	2008	. Agistrar's Signa	B 19	parti									

3. Time of Death

5:15 P.

Birthplace (State or Foreign Country)

**Maryland** 

10d, Inside City Limits

1 Yes 2 No

10, 2008

Frederick

4c. County of Death

10g. Citizen of What Country?

16b. Kind of Business/Industry

20c. Location - City or Town, State

Frederick, Maryland

14. Race - American Indian,

white

Black, White, etc.

USA

Own home

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown

Physician/Medical

þ

Completed

Be

Certification: To

Medical

as attending plant for use as

ed by the s detached t

signed to

cate has t page 2 s

certificate

1 - State Registrar

23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4☐ Pregnant at time of death 9 Unknown

3 □Ectopic pregnancy 5 ☐ Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

24a. Was an autopsy performed:

1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of

1∐ Yes 2x No

death? 2 □ No

3 Probably 4 Unknown

26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

29a. Certifier

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

Manner of Death

Natural

2 Accident

3 ☐ Suicide

4 Homicide

Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as states.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed (ca) se of death (Item 23a) (Type, Print)

Hospital:

Judith E. Karp, MD

1650 Orleans Street, Baltimore, Maryland

State Registrar

31. Date filed (Month, Day, Year) 2008 MAN 1 6

32. Registrar's Signature

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			1 For State	State of M	arylar				lealth a	ind M	ental Hy	_	7111	18	0217	7	
			Registrar  1. Decedent's Name (First, Middle, La	st)	-	Cel	unca	ie oi l	Jeani	-	2. Date of De	Reg. No	(		3. Time of Deat	h	
н	Physici		Martha Jean Dem								Month	10	-	Year .008	1:50	Α <sup>M</sup>	
	/Medic Examir		4a. Facility Name (If not institution, giv		)		4b. City	y, Town, or	Location of	f Death	Jan.	-	. County		1.50	_	
	LAGIIII		Harford Memoria	1 Hospital	1		Н	avre	de Gr	ace			Har	ford			
	Funeral		5. Social Security Number 6. S	iex 7. As		last birthday)		er 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Year,	)	9. Birthp	lace (State or Fore	sign	
	Director		124-28-9785	☐M 2\\ F	69	Yrs.					April 8	3, 19	38	Vi	rginia		
	and		Usual Residence of Decedent  10a, State 10b, County		10c. Ci	ty, Town or Lo	cation							1	0d. Inside City Lim	nits	
	f ehc	ក	Marvland Cec	. 1		Risi	C								1 ☐ Yes 2 🌠	No	
	the 28a	rec	Maryland Cec  10e. Street and Number	T.I.		RISI		ip Code				10g. Ci	tizen of W	hat Coun	itry?		
	13e o	Funeral Director	183 Cree Terrac	e				219	11				US	Α			
	deatl	ner	11. Marital Status	12. Was Decedent Armed Forces		I.S. 13.	Was Dec	edent of H	ispanic Orig	jin? (Spe	cify Yes or No Rican, etc.)	0-		- Americ k, White,	an Indian,		
9	or Ite	교	1 Never Married 2 Married	1 ☐ Yes 2 🔀				2 X No	Specify:	, - 40,10 .			Specify		010.		
8	urel',	d by	3	Year or Dates:					100	Whi	White						
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Iteme 23e or 28e-f ehow he Madieal Examine must be notified at	Completed	15. Decedent's Education (Specify only highest gradual)	ducation ade completed)		16a. Dece (Give	kind of w		during most	of workin	ng	16b. Kind of Business/Industry					
12	within ene. than	duc	Elementary/Secondary (0-12)	College (1-4or	5+)		aitr		,				Food	Ser	vice		
	Hygi Hygi other	Be C	17. Father's Name (First, Middle, Last)							r's Name	(First, Middle						
lan	ould be Mental Merked o	To B										Holderfield					
Maryland	4 5 F F		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route N											State, Zip	Code)		
	1 and 2 Heelth a lem 27 is		Jeanmarie Lowma	n/daughter					race,	Ris	ing Su						
Baltimore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	Removal from State		Place of Dispo cemetery, crei	sition (N. matory or	ame of other plac	ю)		ate -2008	20c. L	ocation -	City or To	wn, State		
Ĕ	permit. Pages Department of I Important: If It any injury or o		4 Donation 5 Other (Specif			T. Foa	ard E	uner				Ris	ing S	Sun,	Maryland	ĺ	
Salt	permit. Pag Department Important: I any Injury c		21. Signature of Funeral Service Licer	see MIC )	16	22 R			ss of Facility		Home.	Ρ.Δ					
ш	70 E # 9		fland (	, // 7	V	î					Home, Risi		un,	MD 2			
н			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each	a the deat ine. A	tn. Do not ent	ler the mo	ode of dyin	g, such as	cardiac o	r respiratory a	irrest,			Approximate Interval Between Onset and Death	i	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a CV+	4										1 day		
	/Medical Examiner		Due to (or as a consequence of):											1 days			
		10	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consec	quence of):	- ru	mo	VICLE	<del>ye</del>					7		
	uted J Insit	Examiner	cause. Enter Underlying Cause (Disease or injury														
Ć	be executed icien and buriel-transit	Exa	that initiated events resulting in death) Last	Due to (or as	a consec	quence of):											
760,	ate be executed hysicien and he buriel-transit	cal		d													
99	ng ph	Jed	IF FEMALE:		- 171												
Вох	The law requires that the death certifica are hes been signed by the ettending ph page 2 should be detached for use as if	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			Ectopic	pregnancy					23d. Date Mor	e of delive	Day Year		
O.	e dea the et ned fo	sici	1 Yes 2 No	4☐Pregnant a 9☐ Unknown	it time of c	death 5	Other (	specify)							ou,		
P.0	hat thed by detacl	F	Part II. Other significant conditions of	contributing to death l	out not res	sulting in the u	nderlying	Cause div	en in Part I		23e. Did	tobacco	use contr	ibute to th	ne cause of death	?	
ds,	signe b pe c	l by	Dementia	is south		Juning 117 (110 G	indony ing	00000 g.v.	OI				,		ably 4 Unkno		
Records,	w requir been si should	Completed	11-11		-						24a. Was		24h V	More auto	psy findings availa	able	
Rec	sicien: The law certificete hes l irector, page 2 s	d L	<u> </u>								auto	psy ormed?	F	prior to con leath?	mpletion of cause	of	
<u></u>	n: Th	မ င၀	25. Was case referred to medical						OC Diago	of Death	1 Yes	2/Z No	0 1	Yes	2 No		
₹	Physicien: this certificated director,	To Be	examiner?	Hospital:	ent 2	] ER/Outpatier	nt 3□ [	Oth	or		<i>(Check only</i> ne 5 ☐ Res		6 □Oth	er (Snecif	v)		
Division of Vital	iding Physicien: th. : After this certifice funeral director, p		27. Manner of Death			28b. Time o					8d. Describe						
<u>ö</u>	Attending ir deeth. ector: After by the funer	atlo	27. Manner of Death  1							No							
<u>Vis</u>	l or Attendi efter deeth. Director: A I in by the ft	tt tt	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		jury - At h	ome, farm, str	reet, facto	ory, office		2	28f. Location (			er or Rura	l Route Number,		
ā	rs eft	Cer				• • • • • • • • • • • • • • • • • • • •											
	To the Hospital or Attent within 24 hours efter deet to the Funeral Director: completely filled in by the	Medical Certification:	(Check only 2 Medical Exer	ysicien: To the best niner: On the basis of	of my kno of examina	owledge, deat ation and/or in	h occurre vestigatio	d at the time	ne, date and pinion, deat	d place, a	and due to the	cause(s	s) and ma id place, a	nner as stand due to	ated. the cause(s)		
	the the mplet	Med	one) 29b. Signature and title of certifier	and manner s	tated.		2	9c Licensi	e oumber		T	29d D:	ate signer	d (Month	Day, Year)		
	5 ± 5 8		PIP		$\sim$	7	-	DA	12/26	78-2	7	1	1,51	08			
7	-		· WIKE	nomploted as a	///	<i>D</i>	Deint'	VU	000	<i>JU</i> ∞	1	. 11	10/				
			30. Name and address of person who	completed cause of	ueath (Itei )	m 23a) (Type, Harfordature	ront)	nem	prins	6 11	ospita	l					
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	rar's Sign	ature	. /			/ .	1						
	Registr		IAM 1 5 200	8	. 1	Color	ALL										

Demmick, Marthe

Division or Vital Records, P.O. Box 68760 Hospital or Attending

n 24 hours airen un 24 hours airen un 24 hours airen 24 hours airen 24 hours airen 25 hours aire

the

2

Medical

E. LATTIN 31. Date filed (Month, Day, Year) State JAN 1 5 2008 Registrar

29b. Signature and title of certifier

(Check only one)

101 COLONIAL 62. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, Suite A.

29c. License number

0002832

29d. Date signed (Month, Day, Year)

Rising Sun MO

			For State Registrar		State	e or ivia	iryiano	•	irtment of tificate o			entai Hy	giene Reg. No.	2008	021	79		
	~		Decedent's Nam	ne (First, Middle, I	_ast)							2. Date of De		Year	3. Time of De	ath		
Phy	sicia edic	_	RICH	ARM		W.			FINK			JAN			13:12	М		
	mine	- 4	4a. Facility Name (			4b. City, Town	, or Location	of Death	LARY	4c.	County of Dea	ith						
				ove Adve				Rockvi		-0411-		Montgomery						
Fune Direc	-		5. Social Security 1	3322	. Sex 11∕2 M 2□	F	79	st birthday) Yrs.	If Under 1 Yes Months Day		Min.	8. Date of Bi (Month, Di Aug. 2	ay, Year)	0	rthplace (State or Fo ountry) Georgia	oreign		
land		-	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location												10d. Inside City L	_imits		
Mary I-f sh	2	tor	MD	Montgo	merv		Rocl	kville							1 <b>½</b> Yes 2[	□No		
h the r 28a	2	Director	10e. Street and Number						10f. Zip Code	е			10g. Citiz	10g. Citizen of What Country?				
th wit	100		3 Hardwi	icke Plac	e				2085					U.S.A.				
rdea		Funeral	11. Marital Status		Arme	Decedent E d Forces?			Was Decedent of Yes, specify C		Origin? (Spec an, Puerto F	cify Yes or No Rican, etc.)	0- 1	<ol> <li>Race - Am Black, Wh</li> </ol>				
INIGITY IN THE CALL IN TOURS After death with the Maryland d 2 should be filed within 72 hours after death with the Maryland thand Mental Hygiene.  This marked other than "natural", or items 23a or 28a-f show than marit be mortified at the morth or morth	Evalling	۵	1 ☐ Never Mar 3 ☐ Widowed	rried 2⊠ Married 4 Divorced	I 1 X 1 Yes	res 2   N s, Give or Dates: 5	%ir F 50-55		1□Yes 2 <b>⊠</b> N			Specify: White						
"natu	C C	lete	(Spe	15. Decedent's ecify only highest	rade completed) (C			16a. Deced (Give	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			g	16b. Kir	ind of Business/Industry				
withir iene.	NA DE	Completed	Elementary/Sec	ondary (0-12)	Colle	ge (1-4or 5 5+	+)		corney				La	w				
2 should be filed withing and Mental Hygiene.  Is marked other than		Be C								18. Mot	her's Name	(First, Middle	, Maiden Surname)					
Aenta Aenta rked		일	Adrian Fink								Esther	Wein	stein					
2 should and Men is marke			19a. Informant's Name/Relationship (Type. Print)					19b. Mailir	ng Address (Stre	eet and Num	ber or Rural	Route Numl	ber, City or	Town, State,	Zip Code)			
and and and and and and and and and and	5			3. Fink -	- Wife		les s		dwicke			ville,			T 0111			
ges 1 Figer 1	5		20a. Method of Dis 1X Burial 2	sposition 2	Removal	from State	20b. Pla	ace of Dispo emetery, crei	sition (Name of natory or other p	olace)		ate	20c. Lo	cation - City o	r Iown, State			
t. Pa rtmen rtant:	) In			5 Other (Spe					em. Gdns		1/13/			ey, Ma				
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is	once,		21. Signature of F	ald. C.	Litte	tille	my	£ď 10	Name and Adward Sa Ward Sa 91 Rock	gel Fi ville	ineral Pike	Direc Rocky	tion ville	, Inc. , MD 20	0852			
			23a. Part1. Enter shock, or he	the disease, or co eart failure. List or	omplications to ly one cause	hat caused on each lin	th ath.	. Do not ent	er the mode of	dying, such a	as cardiac or	respiratory	arrest,		Approximate Interval Betwee Onset and Dea	en ath		
Physici	-		Immediate Cause disease or conditi	(Final	a	_		ATI			ROAL			TION	30 MI			
/Medio			resulting in death)	1	Du	e to (or as	a consequ	ence of):										
	- 4	<u>_</u>	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events  c. RECURRENT AFNATION AW AYPOXIA									1 Hours	2					
peir l		Examiner	cause. Enter Und Cause (Disease o	( DC	=	AD	DATI	4 V.0	· h n n	∨Dr~	143	MONTH						
exect n and islates	מויומ	Exa	resulting in death)	ng in death) Last  Due to (or as a consequence of):						30 + ((	<u> </u>	WOO 11	(; 0 /	17-1	1-00			
riflicate be executed by physician and gother by the physi	2	edical		•	d	5	RO	KE						YBARS	5			
rtifica ng ph	SS		IF FEMALE:				-								-			
The law requires that the death certificate be executed the has been signed by the attending physician and consolor as the buriet transit	iciled loi use	hysician/M	23b. Was decede in the past 1:	as decedent pregnant the past 12 months?  Yes 2 No   No   No   No   No   No   No   No									23d. Date of d Month	delivery Day Year				
s that	neige	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did	tobacco u	co use contribute to the cause of death?				
requires t	o nin											1 🗆	Yes 2)	5µ0 3□	Probably 4 □Unk	known		
The law rete has be	aye z snc	Completed										24a. Wa: auto per 1∐ Yes	s an opsy formed? 2X No	24b. Were prior to death'		ailable se of		
lan: Janitriffica	. joj.	BeC	25. Was case reference	erred to medical						26. Pla	ace of Death							
hysice		To	1 ☐ Yes 2	X <sub>No</sub>	Hospital:	1 Inpatie			IL SEL DOM					6 □Other (Sp	necify)			
Ing Pt	l an		27. Manner of Dea	5 Pending		Date of Inju (Month, Daj	ry y Year)	28b. Time o Injury		njury at Work?		8d. Describe	how injur	y occurred				
ttend Jeath.	911	cati	2 ☐ Accident 3 ☐ Suicide	investiga 6 ☐ Could no	t be	Place of ini	IDV - At hor	me farm str		I ☐ Yes 2		8f Location	(Street an	d Number or	Rural Route Numbe	er		
after of Direction by	d III by	Certification:	4 ☐ Homicide  5 ☐ Homicide  4 ☐ Homicide  5 ☐ Homicide  4 ☐ Homicide  5 ☐ Homicide  4 ☐ Homicide  5 ☐ Homicide  4 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  4 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  6 ☐ Homicide  5 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  7 ☐ Homicide  6 ☐ Homicide  7 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  9 ☐ Homicide  9 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  2 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  6 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8								own, State	and Number or Rural Route Number, ate)						
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has accordingly in but the funeral director and a	erery rille	Medical C	29a. Certifier (Check only one)	1 Certifying 2 Medical E	xaminer: On		f examinat								as stated. ue to the cause(s)			
To the within To the	сощь	Me	29b. Signature an	nd title of certifier	0 = 0	\			29c. Lic	ense numbe	er		29d. Dat	e signed (Mo	nth, Day, Year)			
6			1	Zennin !	78	Glen	م ر ح	ND	. 1	300 C	065B	30	JF	sand	10,200	8		
-			30. Name and add		ho completed	cause of d	leath (Item	23a) (Type,	Print)			1						
				MIE P.	Wast			9901		AL	CENT	ERD	2 R	TKU	LLE, My			
Re	Sta gistr		31. Date filed (Mo		2008	32 degistr	ar's Signat	ture	ente									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2 Month **Physician** January 2008 2032 Thomas Green /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2□ F 55 Yrs. Jan 1952 D.C. 10 214-62-1381 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Crownsville Maryland Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1284 Bacon Ridge Rd. 21032 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuhan, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 2 X No 1 Never Married 20 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Truck Driver Santee Trucking Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Stewart Blake Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Green(Wife) 1284 Bacon Ridge Rd. Crownsville, Md. 21032 20c. Location - City or Town, State 20a. Method of Disposition Date 20b. Place of Disposition (Name of In Icemetery) Chernal Stor other place) 1 Burial 2 Cremation 3 Removal from State Memorial Gardens 1-10-08 Annapolis, Md. 4 □ Donation 5 □ Other (Specify) Wantame Rose of Sacilisons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 M00483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician VONC /Medical Due to (or as a consequence of): Examiner MC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or consequence of): Examiner the burial-tran Due to (or as a consequence of): physician Physician/Medical use as t attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year 5 ☐ Other (specify) 4□Pregnant at time of death ate has been signed by the a page 2 should be detached in 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Dknown Completed 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) funeral director Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 000 2 ER/Outpatient 3 DOA မ 1 Tyes 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I TSertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and j 0 s of person who completed cause of death (Item 23a) (Type, Pri 30. Name and addr

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

or Attending Physiclan:

the Hospital

Division or Vital Records, P.O. Box 68760

State Registrar

31. Date filed (Month, Day, Year) JAN 1 0 2008

Registrar's Signature

			For State	State o	f Marylan		artment <i>rtificate</i>			and M	lental Hy	-	20	A R	0.2	18
			Registrar  1. Decedent's Name (First, Middle,	Last)		Cei	inicate	OI L	Calli		2. Date of D				3. Time	of Death
	Physicia		Jav M.	Grodin							Month Janua	ry 10		Year 2008	9:21	. A. M
	/Medic Examin		4a. Facility Name (If not institution,		mber)	•	4b. City, T	own, or l	Location o	f Death		4c.	County	of Death		
				ban Hosp			Beth If Under 1			041150			lont	gome		
	Funeral			S. Sex M_DM 2 □ F	7. Age (In yrs.	Yrs	Months	Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D	ay, Year)	140	Cour	itry)	e or Foreign
4	Director		075-30-7663 Usual Residence of Decedent			67					Feb. 1	15 و 2.	740	renns	syrva	ша
	yland <b>how</b> at		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1		City Limits
	e Maı <b>a-f sl</b> tifled	ctor	Maryland Montgo	nery	Pot	tomac						r				es 2 □ No
	or 28	Dire	10e. Street and Number				10f. Zip (							What Cour	itry?	
	eath v s 23a nust	eral	11204 Tara Road	12 Was Dec	edent Ever in U	S 13 1		0854		nin? (Sne	ecify Yes or N			A.	an Indian,	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 X Marrie  3 □ Widowed 4 □ Divorced	Armed Fo	orces? 2□NoAir: ve ates:1966-	force	fYes, speci 1 □ Yes 2			, Puerto	ecify Yes or N Rican, etc.)			ck, White,		
2	n 72 houi "naturai edica Ex	Completed t	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	dent's Usual kind of work DO NOT use	Occupa done di retired)	tion uring most	t of worki	ing	16b. Kii	nd of Bu	usiness/In	dustry	
717	iled withi Hygiene. ther than nt, the M	Сотр	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Li	College (	1-4or 5+)		ysicia	n			(First, Middle			ical		
<u></u>	d be tental ked or	To Be	Irving Grodin						R	uth	Duboff					
<u> </u>	shoul and M marl	F	19a. Informant's Name/Relationshi				-				al Route Num				Code)	
Ž	and 2 saith a n 27 is		Linda W. Grodin	- Wife					l, Po		c, Mar					
	Pages 1 nent of He int: If iten iny or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	Place of Dispo c <i>emetery, crei</i> ng Davi	natory or oti	<i>ner pl</i> ace			13 <b>,</b> 20			City or To		
ם	permit. Departn Importa any inju		21. Signature of Funeral Service Li	censee	Hemes	25 I	Name and Danzan 170 R	Address Sky- OCKV	s of Facilit -Gold /ille	berg Pik	Memor e, Roc	ial C kvill	hap Le,	els, Maryl	Inc.	2085
t	31113		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that only one cause on e	caused the leaf	th. Do not ent	er the mode	of dying	, such as	cardiac	or respiratory	arrest,			Approxin	nate Between
	Physician		Immediate Cause (Final disease or condition	, C.	MOTO	PULN	LOWM	4	M	WS	7				Onset ar	id Death
	/Medical Examiner		resulting in death)	Due to	MDTO (or as a conseq ONON	uence of):	117	204		72	Az					· ·
	Adminier	<u>.</u>	Sequentially list conditions,	D	(or as a conseq		440	109	E)	150	113C					
	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Duc to	(0) 40 4 0011009	acinoc on.										
	execu n and lal-tra	Examiner	that initiated events resulting in death) Last	c	(or as a conseq	uence of):										
500	ate be executed obysician and the burial-transit	lical		d												
5	rtifica ng ph	Med	IF FEMALE:							-		T	_			
5.00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live I	tcome pf pregna birth 2 □ Feta nant at time of c own	al death 3	Ectopic pre Other (spe					2		te of delive onth	ery Day	Year
-	that the ed by detac		Part II. Other significant condition	s contributing to d	eath but not res	sulting in the u	nderlying ca	use give	n in Part I.		23e. Did	I tobacco u	ise cont	tribute to t	he cause	of death?
3	uires 1 sign 1d be	d by									1□	]Yes 2[	□ No	3 ☐ Prof	ably 4	Unknowr
2	w rec	lete									24a. Wa		24b.	Were auto	psy findin	gs available
	The Is te ha	Completed									per	opsy formed? 2 No	1	death?	mpletion c	of cause of
0	ilan: ertifica ctor, p	Be C	25. Was case referred to medical examiner?						26. Place	of Deat	n (Check only	one)				
5	hysic this ce	To	1 Yes 2 No			R/Outpatier			4 □ Nu		me 5 Re				(y)	
	ing P	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	1	of Injury nth, Day Year)	28b. Time o Injury	т   28 М	C. Injury Work	at ? ′es 2 □ l		28d. Describe	e how injur	y occur	red		
2	death ctor: / the /	icat	2 Accident investiga 3 Suicide 6 Could no	t be 280 Place	e of injury - At h	ome, farm, str			63 2 🔲		28f. Location	(Street an	d Numb	per or Run	al Route N	lumber,
2	after after i Direct	Certification:	4 Homicide determin		ing, etc. (Speci							òwn, State				
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Medical C		Physician: To the xaminer: On the b												se(s)
	To th withir To th comp	Me	29b. Signature and title of certifier						number			1	1	d (Month,	Day, Yea	r)
	40		Mh 17	0	W		0	00	527	74		1/10	108			
	30		30. Name and address of person w	tho completed cause	se of death (Iter	m 23a) (Type,	Print) SUBU	131	w 1X	15/7	9M			DA V	no	
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 1 4 2	008	Registrar's Sign	ature A	W.									
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician**  $\mathbf{P}^{\mathsf{M}}$ January 10, 2008 G. **Goldstein** 10:45 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery 01ney Brooke Grove Nursing & Rehab Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Min. Days Hours 1 □ M 2 🛣 F Director 543-30-3825 78 January 2, 1930 Oregon Usual Residence of Decedent tha Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County parmit. Pages 1 and 2 should be filad within 72 hours after death with the Maryla Dapariment of Haaith and Mantal Hygiena. Important: if item 27 is marked other than "natural", or teame 23a or 28a-f show amy injury or other traumatic event, tra Medical Examinar traumatics are notified at once. 1 ☐Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 United States 3200 N. Leisure World Blvd., #710 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: Specify 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) **Fabrics** Salesperson 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fanny Cohen 2 Frank Blumberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3200 N. Leisure World Blvd., #710 Silver Spring, MD 20906 husband Carl Goldstein, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 2 € Cremation 3 □ Removal from State 1 D Buriat 4 Denation 5 ☐ Other (Specify) Ft. Lincoln Crematory 1/15/2008 Brentwood, Maryland 21. Signature of uner Laervice Lice 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, MD 20904 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC BREAST 3 months CANCER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death cartificate be executed ettanding physiclan and I for usa as tha burial-trai that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by INFARCTION 2 No 3 Probably 4 Unknown 1 ☐ Yes OCMDIAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Tes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 118726 11 2003 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DLAKY 20832 18111 PainePh. FRAMIN DUSCES GOLD 31. Date filed (Month, Day, Year) 32. segistrar's Signature State 14 2008 Registrar

			1 _ State	tate of Marylan	•	artment of F		and Me		ene g. No. 200	8 02183
5.25			Registrar  1. Decedent's Name (First, Middle, Last)					2	. Date of Deatl	1	3. Time of Death
	Physici		Richard Harold Gorn	·e11					<sub>Month</sub> January	Day Ye	
4	/Medic		4a. Facility Name (If not institution, give stree			4b. City, Town, o	or Location o		, <u>u</u>	4c. County of E	
7			Union Hospital			E1kt	on			Ced	ci1
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under :	Min.	Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
ZA.	Director		219-20-9856 <sup>1X) M</sup>	79	Yrs.			I	Teb. 12	, 1928	Maryland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation					10d. Inside City Limits
	f sho	ö			D D						1 ☐ Yes 2 🎇 No
	the N 28a-i notifi	Director	Maryland Cecil  10e. Street and Number		Port De	10f, Zip Code			10	Og. Citizen of Wha	t Country?
	with 3a or 1 be	Ö	7 Stayman Drive			219	04			USA	
	ms 2,	Funeral	11 Marital Status 12. V	Was Decedent Ever in U.	S. 13. \	Was Decedent of H		gin? (Specit	y Yes or No-	14. Race - /	American Indian,
ထ	or Iter		1 ☐ Never Married 2 ☐ Married	Armed Forces? I ∐Yes 2 X No f Yes, Give		r Yes, specify Cub 1 ∐ Yes 2 🔀 No		i, Pueno Rio	can, etc.)		White, etc.
5-0036	72 hours after death with the Maryland natural", or Items 23a or 23a-f show dical Examiner must be notified at	l by	3 ☐ Widowed 4 X Divorced	rear or Dates:		ILLIES ZMINO	Opecity.			Specify:	White
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<u></u>	should mark math	မ	19a. Informant's Name/Relationship (Type, I		19b. Mailir	ng Address (Street				City or Town, Sta	ite, Zip Code)
	5 # 12 # rd		Michael B. Gorrell/	'Son	10 Wi	lson Roa	d, Ri	sing S	Sun, MD	21911	
ē,	s 1 a of Hea Item		20a. Method of Disposition	20b. F		sition (Name of matory or other pla		Dat		20c. Location - City	y or Town, State
E	Pages nent of l int: if lite		1 X Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	oval from State		tingham		-16-2	008	Colora, N	Maryland
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee	01	22	2. Name and Addre			Home,	ъΔ	
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			23a. Pan . Enter the disease, or complication should be a failure. List only one	is that caused the death	h. Do not ent	er the mode of dyi	ing, such as	cardiac or r	espiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immedia e Cause (Final disease or condition	Laxxna	NE CL	1 Ca	50	oni	Ma		> 5 4 55
	/Medical Examiner		resulting in death)	Due to (or as a cons	uer ce of):						
	Lxammer	<u></u>	Sequentially list conditions, b	Due to (or as a conseq	nence of).						
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a correct	deride oi).						
	al-tra	Examiner	that initiated events c resulting in death) Last	Due to (or as a conseq	uence of):						
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dical	d.								
9	tificat g phy as the	ledi									
Вох	death certifica attending ph I for use as t	Physician/Me	23b. was decedent pregnant	f yes, outcome pf pregna 1 □ Live birth 2 □ Feta		Ectopic pregnanc	ev.			23d. Date o	· .
	ed for	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of d 9□Unknown		Other (specify) _	-,			Month	Day Year
P.0	that the de led by the a detached	h,	9 🗆 Unknown						OGo Did tob	account in a contribu	te to the cause of death?
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Division	I or Attending Physician: after death. Director: After this certifica I in by the funeral director, I	Certification:	E tooldon	8e. Place of injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28			or Rural Route Number,
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physicia	n: To the best of my kno	wledge, deat	h occurred at the t	ime, date ar	nd place, an	d due to the ca	ause(s) and manne	er as stated.
	n 24   n 24   he Fu pletel	Medical		On the basis of examina and manner stated.	ation and/or in	vestigation, in my	opinion, dea	ath occurred	a at the time, d	ate and place, and	
	To the To the Comp	M	29b. Signature and title of certifier	224		29c. Licens		,	1	9d. Date signed (A	
			Jose VIVa	INID.		DH	471	6	-	lanua	14 11, 2008
	6		30. Name and address of person who compl	eted cause of death (Iten	n 23a) (Type,		7	1	•	Ma	,
	<u> </u>		111 W. High S	32. Registrar's Signa	Ktor	W.	IJ.	7	ose	1110	
	Sta Registi		31. Date filed (Month, Day, Year)	Se. Hegistial's Signa	Lord	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a-f per man 25,01/28/08dhb 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician WESLEY GORDON JANUARY 13,2008 WILLIAM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON WASHINGION COUNTY HUSPITAL HAGGRSPUWN If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex **Funeral** Months Days Hours Min. 1**⊠** M 2□ F 212-24-3302 79 PA Director December 25,1928 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c, City, Town or Location 10a State 28a-f show 1**X**Yes 2□No ral", or Items 23a or 28a-f sl Examiner must be notified Director Williamsport MD Washington 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21795 USA 15729 Fenton Avenue Funeral 14. Race · American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify Completed by 3 ☐ Widowed 4 ☐ Divorced White 'natural' 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture the Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Ella May Miller Irvin W. Gordon ပ and N 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 11605 Ernstville RD Big Pool, MD 21711 Gloria J. Armstrong/Daughter permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Stone Bridge Brethern 01/16/2008 Hancock, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 141 West Main Street -Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complicated is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 DAYS **Physician** CLOSED MURAD /Medical Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXCHANGE Sequentially list conditions, if any leading Course. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed 8650 INTRACOLUBRAL Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Division or Vital Records, 1 🗆 Yes 2 No 3 Probably 4 Unknown SUSDULAL CHRONIL Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No DISONDER 24a. Was an SUZURE autopsy performed? 2 □ No 1☑ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Hospital or Attending Pl 24 hours after death. Funeral Director; After ti 27. Manner of Death 1 ZiNatural 5 Pending investigation 1 ☐ Yes 2 🙀 No Unknown M Probable multiple falls 2X Accident Unknown 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Unknown Unknown the Funeral 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the Masis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

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CARUSO

31. Date filed (Month, Day, Year) JAN 2 9 2008

address of person who completed cause of death (Item 23a) (Type, Print)

17 WESTERN

29b. Signature ar

M

32. Registrar's Symature

JANKWA-1

29c. License number

MAGERSPUN.

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month/8/2008 Theodore Lynn Hullihen **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner**

9:45ам

Anne Arundel

Funeral Dir permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 Phys /Me Exar Division or Vital Records, P.O. Box 68760,

383 Hall Rd.

To the Hospital or Attending Physician: The law requires that the death certificate be executed

neral ector		5. Social Security Number 208-20-9236	6. Sex 7. Age (	In yrs. last birt	rhday) II Yrs. N	f Under 1 Year Ionths Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, 7/2/192	Year) 2.7	9. Birt Co	thplace (State or Foreign buntry) PA
ifled at	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Anne A	Arundel	Oc. City, Town								10d. Inside City Limits 1
ust be not	Funeral Director	10e. Street and Number 383 Hall Rd.				10f. Zip Code	1032		10	ng. Citizen of USA	What Co	ountry?
important, it reflects to finance other train flavoral, or reflects and or coart show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? ied 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		1	s Decedent of Hes, specify Cuba		in? (Spec , Puerto Ri	ity Yes or No- ican, etc.)		ck, White	encan Indian, e, etc. White
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c event, th	To Be Col	17. Father's Name (First, Middle, EK Hullihen	Last)		Tuck	DIIVEL		's Name (	(First, Middle, N			1011
er traumati	-	19a. Informant's Name/Relations Linda Darr I	hip <i>(Type. Print)</i> Daughter			Address (Street a			Route Number,			Zip Code)
ury or othe		20a. Method of Disposition 1		20b. Place of cemeter Watts	Ceme	-	1,	Da /19/2	2008	oc. Location	od,	PA
any Inj once.		21. Signature of Funeral Service	fr-		12	ame and Addres Ridgely	Ave.	Ann	apolis,	MD 21		e, P.A.
cian		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a Conse	stive	H	he mode of dyin	g, such as o	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
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fould be detached for use as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a d									
as the	ledic		d									
hed for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal death		topic pregnancy					ate of del onth	livery Day Year
uld be detac	ted by Ph	Part II. Other significant condition	ons contributing to death but	not resulting in	the unde	rlying cause give	en in Part I.		23e. Did tob			o the cause of death? robabły 4 □Unknown
page 2 sho	Complete							<del></del>	24a. Was ar autops perform 1∐ Yes 2	v	prior to death?	utopsy findings available completion of cause of c
rector,	Be	25. Was case referred to medical examiner?	Hospital:			2□ DOA Othe	ar.		(Check only one			
completely filled in by the funeral director, page 2 sh	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date of Injury (Month, Day)		ime of njury	28c. Injur	4 ⊔ Nur		e 5 MReside 3d. Describe ho	nce 6 □Ot w injury occu		icity)
ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could a determ		- At home, fai (Specify)	m, street,	, factory, office		28	Bf. Location (Str City or Town		ber or Ri	ural Route Number,
pletely fill	Medical	(Check only 2 Medical	Physician To the best of Examiner: Or the basis of e and manner state	xamination and	d/or inves	tigation, in my o	pinion, deat	th occurre	d at the time, da	ate and place	, and due	e to the cause(s)
ē .	Š	29b. Signature and title of certifie	Iller	~ M	0	29c. License	816	6	- 29 - U	Oute signe	ed (Mont	in, Day, Year) 7 <sub>1</sub> 2008 er <sub>7</sub> m0 21037
	X	30. Name and address of person  Enc C. Mai	who completed cause of dea	th (Item 23a) (	Type, Prir	nt) "cuson'tan	C/	Sin	Je 101	Edes	we to	er and 21057
Sta egistr		31. Date filed (Month, Day, Year)	2008 32 egistrar	s Signature	for	where	91/			Je		

Crownsville, MD

Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year.

JAN 1 0 2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Benjamin L. Hopping III 2008 1400 Jan. 6 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Salisbur a Rehaba Nursing Cto Wicomico alisbury 9/7/1948 5. Social Security Number 6. Sex ast birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **M** 2 □ F Months Days Hours Min. Maryland 216-48-7523 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Worcester 1 □Yes 25 No Snowhill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5940 Public Landing Rd. 21863 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes ②☑No If Yes, Give Year or Dates: 1 ☐ Yes **ZX**No White Specify 3 ☐ Widowed 4 ☑ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Worker State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Hopping Jr. Beverly Erickson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erica L. Young Daughter 5940 Public Landing Rd. Snowhill, MD 21863 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Hillcrest Cemetery 1/10/2008 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 Signature of uneral Service Licensee Dalas 12 Ridgely Ave. 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in gach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition disease or condition resulting in death) 1000 ear. 5 Due to (or as a conseque the too Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Du to (or as a consequence of): Due to (or as a consequence of): If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2 1No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Show

ral", or Items 23a or 28a-f shov Examiner must be notified at

'natural', or

Is marked other

permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau

ould be

njury or other traumatic event,

Baltimore, Maryland 21215-00

Director

Funeral

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Completed

Be

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and attending physician the as nse Į. the signed by has certificate director

the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician;

the

Examine Physician/Medical þ Completed Be 2 within 24 hours after death.

To the Funeral Director: After to completely filled in by the funers Medical Certification:

25. Was case referred to medical examiner? Hospital 1 Tyes 2**...**₩6 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Iniury 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

29a. Certifier

31. Date filed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

WilliamH Robins M.D. 200

Registrar

JAN 1 0 2008

08-00395 Julie Ann Hutzell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			ate of Dea	ith	tai i iy	_	eg. No.	200	8 0218
Physicia		Decedent's Name (First, Middle,Last)					- 1	2. Date of Deat Month		Year	3. Time of Death
ledical Exami	ner	Julie Ann Hutzell  4a. Facility Name (if not institution, give street a	- 1		La Si			Month January 14			10:31 a.m.
		Washington County Hospital	ng number)			Town, or Location o erstown	of Death		Wash	ty of Death ington	
Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birth			r 24Hrs.	8. Date of Birt			hplace (State or
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any		10a. State 10b. County	100	. City, Town	or Location						10d. Inside City Limits
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Aaryla 28a-f 1 at or	Director	10e. Street and Number				ip Code		10	Og. Citizen of		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1120 Stanley Ave				17201				U.S.A	
eath w	Funeral	1 Y Never Married 2 Married Arm	s Decedent Evened Forces?		If Yes, spec	dent of Hispanic Orig cify Cuban, Mexican,	gin? (Spe , Puerto F	ecify Yes or No- Rican, etc.)		ace - Ameri hite, etc.	can Indian, Black,
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212 212 ould be Ments mark c even	To B	19a. Informant's Name/Relationship (Type, Print	:)	19b	. Mailing Addres	SS (Street and Num					Zip Code)
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<b>D</b> 52 7 1 1	3	Kaittin Faltar	no				Lvd.	N. Hag	erstow	n Mar	yland 21742
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s, P.O. Be irres that the dear signed by the addeded for the debacked for	a b	Hip fracture status post surgery						1 Yes	2 No	3 Prob	ably 4 🗸 Unknown
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Pysis Kirs	To Be	examiner?  1 Ves 2 No	Inpatient	2 🗸 ER/Ou	tpatient 3	DOA Other			Residence (	6 Other	:
ing Ph After I		27. Manner of Death 28a.	Date of Injury Month, Day, Year)		ime of Injury	28c. Injury at Work?		28d. Describe h			
ion ttendi leath.	Certification:	1 Natural 5 Pending 2 Accident Investigation	77/2007	Unkn	own	1 Yes 2 🗸	No 1	notor vehicl	e comsion		
Divisi ipital or At ours after d ceral Direct filled in by	<b>≌</b>	3 Suicide 6 Could not be 28e.			m, street, factor	y, office building, etc	c. 2	28f. Location (S or Town, S		mber or Ru	ral Route Number, City
D Spita hours neral y fille		20a Cortifier	ecify) unknov					www.Wa	yne Ave.		ersbur, P.A.
Division  To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the b	asis of examina								
To To	Mec	and man 29b. Signature and title of certifier	ner stated.			c. License number					nth, Day, Year)
12		Jako Hod	un)			O.C.M.E.			January		
CXP	-	30. Name and address of person who completed	,	(Item 23a)					l		
22		Tasha Greenberg MD. Assistar	nt Medical E	xaminer	111 Penn	Street, Baltimor	re, MD	21201			
Sta	ite	31. Date filed (Month, Day, Year)	2. Re strar's Si	gnature .	had						

			For State	State of	of Maryla	-	artment of H		1ental Hygie	ene	
			Registrar  1. Decedent's Name (First, Middle	, (not)		Ce	rtificate of I	Death	Reg 2. Date of Death	. No. 2008	02199
	Physicia	an							Month	Day Year 2008	0315 M
	/Medic Examin	- 20	Marvin C. Inc. 4a. Facility Name (If not institution		mber)		4b. City, Town, or	r Location of Death	January	4c. County of Death	
I .	LAGIIIII	۲۱ ادی	1903 Patricia				Westmi	inster		Carrol	.1
-4-	Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birth	place (State or Foreign ntry)
. E	Director		217-26-5610	1 <b>½</b> M 2□ F		77 Yrs.			Feb 11	1930	PA
	and		Usual Residence of Decedent  10a. State 10b. County		10c. (	City, Town or Lo	ocation				10d. Inside City Limits
	Maryl -f sho ied a	to	MD Ca:	rroll		Mostm	inster				1 ∐Yes 2 ☐ <b>X</b> No
	r 28a r notif	Director	10e. Street and Number	-1011		Weban	10f. Zip Code		10g	. Citizen of What Cou	ntry?
	th with	al D	1903 Patricia	Court			2	1158		USA	
	r dea	Funeral	11. Marital Status	Armed Fo		U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
30	s afte	by Fu	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☑ Divorced	ied 1 XYes If Yes, Gi Year or D		orea	1 ☐ Yes 2 🔀 No	Specify:		Specify: Wh	ite
2-003p	within 72 hours after death with the Maryland ene. than "hatural", or items 23a or 28a-f show the Medical Examiner must be notified at		15. Deceden		Jales.	16a. Dece	dent's Usual Occup	ation	16	b. Kind of Business/Ir	dustry
3	nin 72 in "na Medic	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed)	1-4or 5+)	i (Give	kind of work done of DO NOT use retired	durina most of work	ing		,
7	d with giene er tha the I	Som	12	College (	1-401 51)		Police Of	ficer		Baltimore	<u>Co</u>
and	be file tal Hy d oth svent	Be (	17. Father's Name (First, Middle,	Last)					e (First, Middle, Ma	iden Surname)	
<u>X</u>	Men Marken Marken Marken	ဥ	Melvin Ingham					Elva Br			
Nar	d 2 sh chanc 7 is m traum		19a. Informant's Name/Relations	, , , , ,						City or Town, State, Zi	
e O	1 and Healt em 2		Thomas Ingham/ 20a. Method of Disposition	<u>son</u>	20b	. Place of Disp	3 Patrici	01./1		ter, MD 2 c. Location - City or T	1158 own, State
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 【ACremation 4 ☐ Donation 5 ☐ Other (S		State	-	matory or other place Cremation	/	· · · · · · · · · · · · · · · · · · ·	ampstead, 1	MD
Баппо	partmoortar	ł	21. Signature of Funeral Service		1			<u> </u>		pel, P.A.	
ň	permil Depar Impor any in		· Marine	~			112 Washir			nster, MD	21157
	<i>*</i>		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the de each line.	eath. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition	_a. / //	240	MATIC	Ken	n al	con	Chama	Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a cons	equence of):					
	Agrico 4	-	Sequentially list conditions,	b. ————————————————————————————————————	(or as a cons	equence of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	•	,	,					
Ď,	exec an and rial-tra	Еха	resulting in death) Last	Due to	(or as a cons	equence of):					
2/00	icate be executed physician and s the burial-transit	dical		d							
0			IF FEMALE:	T							
X D	death certif e attending d for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		birth 2 ☐ Fe	etal death 3	□Ectopic pregnancy	/		23d. Date of delive	ery Day Year
5	the de	ysic	1  Yes 2  No 9  Unknown	9□Unkr	nant at time o nown	rdeath 51	Other (specify)				
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r	The late happage	Completed							autopsy performe	ed? death?	ompletion of cause of 2 ☐ No
N I G	ctor, g	Bec	25. Was case referred to medica examiner?						h (Check only one)		
2	Physician: this certificanal director,	2	1 ☐ Yes 2 ☐ No			☐ ER/Outpatie		4 □ Nursing Ho		ce 6 □Other (Speci	fy)
	Jing F After funera	ion	27. Manns of Death  Natural 5 Pendin investig	9	of injury oth, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2∐No	28d. Describe how	injury occurred	
SION	Attending r death. ector: After by the funer	ficat	3 ☐ Suicide 6 ☐ Could	not be 200 Place	e of injury - At	home, farm, st	reet, factory, office	163 2 110	28f. Location (Stre	et and Number or Rui	al Route Number.
<u> </u>	after after I Dire	Certification:	4 ☐ Homicide determ	build	ling, etc. (Spe	cify)	,		City or Town,	State)	,
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after cleath.  Within 24 hours after cleath.  To the Functial Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use at		29a. Certifier 1 Certifyir	g Physician: To th	e best of my k	nowledge, dea	th occurred at the tir	me, date and place,	and due to the cau	se(s) and manner as	stated.
	the Hi in 24 the Fi	Medical	one)	and mar	ner stated.	IIIation and/or ii				1 1	
			29b. Signature and title of certifie	1			29c Licens	e number	290	I. Date/signed (Month)	Day, Year)
)	WILVA			7				ارديو		111110	JO8
	2011		30. Name and address of recon	who completed cau	se of death (It	em 23a) (Type	the Monte	or C+	Mactini	netro	UD DIICA
	Sta	te	31 Date filed (Month, Day, Year)	32.1	Raistrar's Sig	nature	111 WILL	11	F 460111111	13101	viv als f
	Registr		JAN 1	4 2008	lower	I A	parti				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Linda Jean Johnson 6, 2008 8:15 &m January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3220 Livingston Rd. Charles Indian Head If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 216-88-5496 Director 52 March 14,1955 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Show 10a, State 10b. County "natural", or items 23a or 28a-f shovidical Examiner must be notified at 1 Yes 2 No Charles Maryland Indian Head 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3220 Livingston Road 20640 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. filed within 72 hours after 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: <u>Ş</u> White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Her Home 10 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked or any Injury or other traumatic eve once. pe John Melvin Wyne Carol Blackburn Pages 1 and 2 should I nent of Health and Men 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1410 Tadcaster Circle, Waldorf, Md. 20602 Jessica L. Johnson Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 15, 2008, Metropolitan Fun. Ser. Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Se M00668 no 4270 Hawthorne Rd., Indian Head, Md. 23a. Part1. Exer the disease, or complications that caused shock, in heart fail are. List only one cause on each line. ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Fire disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed and Due to (or as a consequence of) burial-P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death a I Inknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an , page 2 certificate 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 【Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: stely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide hours after Medical 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 and manner stated. To the

within 2

State

29b. Signature and title of certifie

30. Name/and address of person who completed

(Month, Day, Year)

JAN 1 4 2008

Registrar

cause of death (Item 23a) (Type, Print)

29c. License number

agrange Ave P.O. Box 1317 Caplata, md 201046

			For State	State of Ma	aryland / I	-	rtment tificate			and Me						
18			Registrar     Decedent's Name (First, Middle, Last)			001	imeate		Calli		2. Date of De	Reg. No.	201	18	3. Time of Dea	
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	Funeral		5. Social Security Number 6. Sex	7. Age	e (In yrs. last bii		If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. 1 Min.	8. Date of Bir (Month, Da	th ay, Year)	9	. Birthpl	ace (State or Fo	reign
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	th wit 23a c ist be		1643 Conowingo Road	d				219	11				USA			
	r dea	Funeral	11. Marital Status	2. Was Decedent 8 Armed Forces?	Ever in U.S.	13. W	/as Decede Yes, specif	ent of Hisp fy Cuban	panic Orig	gin? (Spec	ify Yes or No lican, etc.)	)-	14. Race - Black.	America White, e		
ဗ္ဗ	s afte ; or it	by Fu	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N If Yes, Give	No.		□Yes 2]						Specify:			
8	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must <u>be notified at</u>		15. Decedent's Educ	Year or Dates:	16a	Deced	ent's Usual	Occupat	tion			16h Kir	nd of Busir		nite	
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<u>a</u>	ould b Ment arked atic e	2	Russell R. Reynolds	S					Sar	ca Pi	erce					
Baltimore, Maryland 21215-0036	Ø Ø		19a. Informant's Name/Relationship (Typ	ŕ	195	o. Mailing	Address (	Street an	nd Numbe	er or Rural	Route Numb	er, City o	r Town, Sta	ate, Zip	Code)	
aî oî	l and lealth im 27 iher tr		Donna Hovatter/Daug	ghter						ad, R	ising					
ğ	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 X Buriai 2 ☐ Cremation 3 ☐ Re	emoval from State	20b. Place o cemete	ery, crem	atory or oth	e or her place)	4				cation - Cit	-		
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,	Physician /Medical		disease or condition resulting in death)	Due to (or as	e consequence	NO.		NVC	MIC	1	<u>Cespir</u>	1410	<u>vy                                     </u>		1wK	
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X R R	attend for us	Physician/Me	in the past 12 months?	lc. If yes, outcome 1□Live birth 4□Pregnant at	2 Fetal death		Ectopic pred					2	23d. Date o Month		y Day Year	
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J.	that led by deta		Part II. Other significant conditions cont	ributing to death bu	ut not resulting in	n the un	derlying cau	use given	ı in Part I.		23e. Did t	obacco u	se contribu	ute to the	e cause of death	?
<b>Records</b> ,	w requires that s been signed b should be deta	d by	Loctal (	ancev							1 🗆	Yes 2[	□ No 31	☐ Proba	ably 4 □bnkn	own
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n o	ding Pt h. After th funeral		27. Manner of eath 1 □ Natural 5 □ Pending	28a. Date of Injui		Time of Injury	286	c. Injury a Work?	at	28	d. Describe	how injur	y occurred			
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	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Me	29b. Signature and title of certifier		1		29c.	License r	number			29d. Dat	e signed (/	Month, E	Day, Year)	
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	11		30. Name and address of person who con	npleted cause of de	eath (Item 23a)	(Typę, P	rint)	<u> </u>	- /		,	1				
_	7		Barbara 1. Pare	(m)X	111 10.	His	hSt.	<u>-</u> 5	vite	2/4	_ E	IKto	<b>'</b> \	MO	2192	
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	Registr	ar	JAN 1 5 2008	A Second	No di	The second										

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1/プグ2008 Year **Physician** 4:26 am Alma B. Katzenberger /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel **Annapolis** Anne Arundel Medical Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 89 vrs 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 7/14/19 18" Maryland 1 □ M 2 1 1 F 216-01-5702 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County Stevensville MD Queen Anne 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number or 21666 USA 507 Buckingham Dr. rai", or Items 23a Examiner must b by Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23.
ury or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc 1 □ Never Married 2 □ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3X Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John W. Bagwell Neva Arthur P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507 Buckingham Dr. Stevensville, MD 21666 Betty Anne Lerner Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 1/11/2008 Baltimore, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Attensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. d 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ASDILATION duzz disease or condition resulting in death) /Medical Due to (of as a consequence of): Examiner Sequentially list conditions. Examiner iany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed anding physician and use as the burial-transi A(u+e M40 (ard Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FFMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month 5 Other (specify) been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 No Nown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 has autopsy performed: certificate 1 ☐ Yes 2 ☐ No Yes 2 KNo or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2⊠ No 1 Malient Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident the within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 ☐ Homicide filled the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2008 M 30. Name and addr

Registrar

Annapolis, Md

ess of person who completed cause of death (Item 23a) (Type, Print)

001

medical

Sanchez

JAN 1 0 2008

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 0 2 | 9 3

		1	For State Registrar	State of Ma			ficate of L	Death	Re	g. No.	000	ULIJU
Physic	iciar		. Decedent's Name (First, Middle, Last	Kwon					Jan.9,	ີ 2008	Year	3. Time of Death 11:48A M
/Med	dica	1	Yoon Kap  a. Facility Name (If not institution, give			4		Location of Death		4c. Co	unty of Death	
Exam	nine		Holy Cross Hos	pital				r Spring		1	ntgom	place (State or Foreign
Funera Directo			217-72-2303	X 7. Age	74		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 7 O 7 T	933	Cou	intry) Korea
land Dw			Usual Residence of Decedent  Oa. State  10b. County		10c. City, Town							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
Mary a-f she		cto	MD Howard	E .	Clarks	svi]				0- 011	of What Cou	
h with the 23a or 28 st be not	1	Funeral Director	Oe. Street and Number 6937 Crossfield	d Court			10f. Zip Code 2102			U.5	5.A.	
portition of a should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Meckel Examiner must be notified at		2	1. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	1[	Tyes 2√2 No		ecify Yes or No- Rican, etc.)	Sp		Asian
within 72 ho ane. than "natur		Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	+) 16a.	Decede (Give ki life. De uto	nt's Usual Occup ind of work done of NOT use retired techni	ation during most of work (Cian	ing	Auto	of Business/I	naustry
ld be filed vental Hygie ked other ic event, th		To Be Co	17. Father's Name (First, Middle, Last) An Dong Kwon						eyang `	Yoon		
nd 2 shoul alth and M 27 is mari		-	19a. Informant's Name/Relationship ( Allan Kwon/Son		6	937	Crossf		eurt CL	arks	AITTE	,Maz1029
Pages 1 arent of Hezen rit fitem iry or othe			20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Speed)	Removal from State	20b. Place or cemete Ches	ape		em.   1 / 1 2		Bel		le,Md
permit. Pages Department of Important: If it	ouce.		21. Signature of Juneral Service Licent	all		92	41 Colu	RINALDI umbia Bl	.vd.Sil	ver	ERVIC Sprin	g, Ma20910
Physicia	an		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each ii	ile.		r the mode of dyinowel d:		or respiratory ar	rest,		Approximate Interval Between Onset and Death
/Medic	al		resulting in death)	a Due to (or as	a consequence	of):						
ted sit		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or as	a consequence	of):						
68 / 60, ificate be executed g physician and as the burial-transit		edical Exar	resulting in death) Last	Due to (or as	a consequence	of):						
ath cert		Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e pf pregnancy 2  Fetal deat It time of death		Ectopic pregnand Other (specify)	гу		23	d. Date of de Month	livery Day Year
IS, F.C. Ires that the de signed by the a	מבומס	by	Part II. Other significant conditions	contributing to death l	out not resulting	in the ur	nderlying cause gi	ven in Part I.		obacco us Yes 2		o the cause of death? robably 4 ⊠Unknown
Division or Vital Records, to a translation or Vital Records, after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be e	<b>y</b>	Completed								psy prmed?	prior to death?	utopsy findings available completion of cause of
ificate	Ji, pag		25. Was case referred to medical					26. Place of De	1  Yes ath (Check only o	2 🖾 No   one)	1   16:	5 2010
ysicia ysicia is cert		To Be	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpat			1 3 DOA		Home 5 ☐ Resi			ecify)
Attending Physician: Tedath. ector: After this certificator in the physician in the physici	e inneral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D		. Time o Injury	) We	ury at ork? ⊒Yes 2□No	28d. Describe			
Division or Atternated after dead I Director	u ka ui b	Certification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined				eet, factory, office		City or To	wn, State)		Rural Route Number,
Division or Vital Ke to the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he commission filled in by the funeral director.	netely tille	Medical C	29a. Certifier 1 CertifyIng F (Check only one) 2 Medical Ex-	thysician: To the best aminer: On the basis and manners	of examination a	ge, deat and/or in	vestigation, in my	opinion, death occ	e, and due to the curred at the time	, date and	place, and de	Te to the cause(s)
To th	Eoo	Me	29b. Signature and title of certifier	9 Don	als	w		2261		29d. Date	Jan.	9,2008
ľ			30. Name and address of person wh		death (Item 23a	a) (Type,	Print)	Rd. Silv	er Snr	ira .	Md 209	10
	C.	oto	Alan R. Segal  31. Date filed (Month, Day, Year)	MD 15	trar's Signature	est	GTGII I	.u. DIII	OI DEI	5/-		
Reg	St gist	ate rar		2008	strar's Signature	G	seles.					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0945 AM Violet T. Kemp January 11, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Olnev Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🛣 231-01-3534 87 Virginia Director Dec. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 15311 Pine Orchard Drive 20906 IISA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2 🔀 No Specify: þ SpecifiWhite 3 ₩ Widowed 4 Divorced Year or Dates: natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Homee other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Mental if John Edward Terrell Rhoda Violet Marchant 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie K. Decker/Daughter 2716 Martello Drive, Silver Spring, MD 20904 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town State Department of H important: if ite any injury or of once, 1€ Burial 2 □ Cremation 3 □ Removal from State Jan. 15, Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2008 Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd, W., Silver Spr Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner hronic 6 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the the attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an autopsy performed Anenia 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar

Medical

obert 31. Date filed (Month, Day, Year) JAN

14

2008

29b. Signature and title of certifier

(Check only

egistrar's Signature

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18101 Princethil. F

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1)006/681

29d. Date signed (Month, Day, Year)

11 2008

Drive, olney, MD 20832

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year MARY KINNA $\mathbf{L}_{\mathbf{i}}$ M JANUARY 13 2008 6:20P 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days 1□M 2√F 215-26-8777 79 July 9, 1928 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Maryland Frederick Knoxville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4919 Catholic Church Rd. 21758 United States 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Specify: 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) L1oyd Hemp Virginia Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy Blumenouer / Daughter 4935 Catholic Church Rd., Knoxville, MD 21758 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St. Mary's Cemetery 1/17/2008 Petersville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign of Funeral Service Licensee Stauffer Funeral Home 22. Name and Address of Facility e., Brunswick, MD 21716 respiratory arrest, DAYS

**Physician** /Medical **Examiner** 

**Physician** 

Examiner

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

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Department of Health and Mental Hygiene. Important: If item ZT is marked other than "natu any injury or other traumatic event, the Medical ones.

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Baltimore, Maryland 21215-0036

/Medical

10a. State

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Tourmous	tauller 1100 N. Maple A	VΕ
23a. Part1. Enter the disease, or co shock, or heart failure. List on	nplications that caused the death. Do not enter the mode of dying, such as cardiac y one cause on each line.	or
Immediate Cause (Final disease or condition resulting in death)	a. MYOCARDIAL INFARCTION	
resulting in death)	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a consequence of):	_
Cause. Enter Underlying Cause (Disease or injury that initiated events		
resulting in death) Last	Due to (or as a consequence of):	
•	<b>d</b>	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	_
	contributing to death but not resulting in the underlying cause given in Part I.	
25. Was case referred to medical	26. Place of Dea	ith
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	om
27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Year)  28b. Time of Solution   28c. Injury at Work?  Injury   M   1   Yes 2   No	28
3 Suicide 6 Could not 4 Homicide determine		28

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mn

23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery Month

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed

of Dea	th C	heck onl- one		
sing H	ome	5 Residence	6 ☐Other (Specify)	
	28d.	Describe how inju	ury occurred	

8f. Location (Street and Number or Rural Route Number, City or Town, State)

2 No

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- 08

1 Certifying Physician: To the best of my knowledge, death		
2 Medical Examiner: On the basis of examination and/or inversely medical Examiner: On the basis of examination and/or inversely medical Examiner:	estigation, in my opinion, death occurred at the tim	e, date and place, and due to the cause
Etle of cortifier	29c License number	29d Date signed (Month Day Year)

FREDERICK

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

814 TOLL

			_ FOr	Department of Health		ene	0010
			1 - State Registrar	Certificate of Death	3	. No. 4000	02191
П	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	_	Clayton Haynes Keith	4 O T	Jan ua	/	/
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location	of Death	4c. County of Death	
		7	Union Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last by the security Number 1. Security Num	Elkton  pirthday) If Under 1 Year   If Under	er 24 Hrs.   8, Date of Birth		place (State or Foreign
В	Funeral Director		222-14-0149 1⊠M 2□F 81	Yrs. Months Days Hours	# 24 Hrs. 8. Date of Birth (Month, Day, Y	(ear) Cou	ntry) Oelaware
			Usual Residence of Decedent		odij 20,		
	ırylan thow	_	10a. State 10b. County 10c. City, To	wn or Location			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	e Ma 8a-f s	cto		ewark	1		
	vith th	P.	10e. Street and Number	10f. Zip Code	109	j. Citizen of What Cou	intry?
	s 23a	eral	1610 Old Baltimore Pike  11 Marital Status 12. Was Decedent Ever in U.S.	19702 13. Was Decedent of Hispanic O		JSA 14. Race - Ameri	can Indian
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 ★ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 ★ Yes 2 □ No	If Yes, specify Cuban, Mexico	an, Puerto Rican, etc.)	Black, White	
5-0036	irs af	by	If Yes, Give  3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWII	1 ☐ Yes 2 X No Specify	y:	Specify: W	hite
Ö	2 hou	ted	15. Decedent's Education 16	a. Decedent's Usual Occupation	net of working	6b. Kind of Business/Ir	ndustry
218	thin 7 e. an "n Med	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during mo life. DO NOT use retired)	1		_
21	ed wii ygien rer th	S		ruck Driver		Transporta	tion
nd	be fill tat H d oth even	Be	17. Father's Name (First, Middle, Last)		her's Name (First, Middle, Ma	,	
yla	ould I Men narke natic	유	Charles Wesley Keith		elen Marie Hay		
Maryland	d 2 sh h and <b>7 Is n</b> traun			9b. Mailing Address (Street and Num. 610 Old Baltimore		-	
	1 and Health em 2	13	20a Method of Disposition 20b. Place	of Disposition (Name of		Oc. Location - City or T	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 【Cremation 3 ☐ Removal from State ceme	tery, crematory or other place)	01-16-2008	ising Sun,	Maryland
Ħ	nit. Partme ortan Injur.	1	21. Santure of uneral Service Licenses	Foard Funeral Ho		ising sun,	Maryrand
Ba	permit Depar Impor any In once,	0.7	Of a hard of Sandie	R. T. Foard and 122 West Main	d Jones, Inc. Street. Newarl	k. DE 1971	1
ė.			23a. Part1. Enter the disease, or complication that caused the death. Distortion of the country one country on each line.				Approximate Interval Between
	Physician	2.3	Immediate Cause (Final				Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence	-			LWURS
	Examiner		Sequentially list conditions b. Non-Smy	ell cell lung	Cancer		14 month
	p ±	iner	Sequentially list conditions, it dry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a city			
	icate be executed physician and s the burlal-transit	Examin	Cause (Disease or Injury that initiated events resulting in death) Last c	o off:			
8760,	be ex cian curial	Ē	Due to (or as a consequence	e 01).			
387	icate physi	dical	d				
9 X	w requires that the death certifi been signed by the attending I should be detached for use as	/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of deli	verv
Вох	atter after I for u	ciar	in the past 12 months?  1 □ Yes 2 □ No  1 □ Yes 2 □ No			Month	Day Year
0	the c y the	hysi	9 ☐ Unknown				
σ,	s that ned be e det	Y P	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Par	t I. 23e. Did toba	cco use contribute to	the cause of death?
Records,	equire en sig ould b	Completed by Physician/M			112 Yes	2 No 3 Pro	obably 4 □Unknown
တ္ထ	2 33 2	plet			24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
Ä	The law ate has b page 2 st	l m			performe	ed? death? No 1 □ Yes	
Vital	ysician: The law is certificate has be director, page 2 s	Be (	25. Was case referred to medical examiner?		ce of Death (Check only one)	)	
7	> .07 0	은	1 ☐ Yes 275 No Hospital: 1 1 Inpatient 2 ☐ ER/0		Nursing Home 5 Residen		cify)
n o	ing F	ü	1/⊠Natural 5 □ Pending (Month, Day Year)	o. Time of 28c. Injury at Work?  M 1 Pres 2	28d. Describe how	vinjury occurred	
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Division or	or A after of Direct in by	Certification:	4 Homicide determined building, etc. (Specify)	iam, stroot, ractory, smoo	City or Town,	State)	ia riodio rambo,
_	Hospital 4 hours a Funeral tely filled		29a. Certifier 1 Certifying Physician: To the best of my knowled				
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Examiner: On the basis of examination one) and manner stated.	and/or investigation, in my opinion, d	leath occurred at the time, da	te and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month	
			M. Forkos, ND	P1531	14 ]	on uares 1	1.2008
	Que IN		30. Name and address of person who completed cause of death (Item 23a	a) (Type, Print)	N. Bridge	1 - 11.	,
	Ser IVA		It Farkes, MD Sasons	1705 pice, 133.	N. bridge	51., E/KI	On,/10
	Sta		31. Date filed (Month, Day, Year)  JAN 1 5 2008  32 Registrar's Signature	South ?	,		
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DHMH 17 Rev 1/2001

Amended Item 20b per F.D. 01/14/2008 Carroll County, wil Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2008 10:12 A.M Elsie Cordelia Long 10 01 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Carroll hospital Center westminster If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08/24/1922 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months **8**5 218-16-2049 1 M 2 X DE Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 □Yes 2√□No Director MD Carroll Hampstead 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21074 United States 3795 Castle Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Residence Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Milton Bunting George Hubert ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3795 Castle Drive, Hampstead, MD 21074 Maynard W. Long - Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of Carendyl Creditions)

Carroll Crmation 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/16/2008 Hampstead, Maryland 22. Name and Address of Facility Eline Funeral Home, 934 South 21. Signature of Funeral Service Licensee M01490 Main Street, Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9∏Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 🐪 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∏ Yes 2 DaNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 □ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, the as asn for detached page 2 s has director

and burial-tran To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

**Funeral** 

Director

"natural", or items 23a or 28a-f show ediral Examiner must be notified at

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permit. Pages 1 and 2.
Department of Health a Important: If item 27 is any Injury or other trau

**Physician** 

/Medical

Examiner

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

NSI 4 State

Medical

29a. Certifier

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

thwoods Trail Hampste

re and address of person who completed cause of death (Item 23a) (Type, Print) exander

31. Date filed (Month, Day, Year)

4

JAN

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 4, 2008 Month **Physician** Helen Adeline Lancaster 7:55 рМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Day) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2√F 217-32-4887 1929 Director July 20, Maryland Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Prince George Capital Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 505 Nova Ave. 20743 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 2 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Her Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fill and Mental H Be Louis A. Hurd Helen M. Dotson ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 I Doris L. Lancaster Daughter P.O. Box 851, Waldorf, Md. 20604 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ite any Injury or ot 1 Magazial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 14, 2008 Jan. Cheltenham, Maryland Maryland Veterans Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Facility Williams Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately and the death of t Approximate Interval Between Onset and Death Immediate Cause Final Physician disease or condition resulting in death) DNeummia /Medical Due to (or as a consequence of) Examiner ementia Sequentially list conditions, if any, leading to immediate cause. Each of onlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical the for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has page 2 autopsy death? 2□No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 1/2001

ess of person who completed cause of death (Item 23a) (Type, Print)

IANNER My

Registrar's Signature

Day, Year) N 1 4

31. Date filed (Month

035206

11701 LIVINGSOM Road For WASHINGTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year 2:30 AM Chris A. Lester 2008 JANU AR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days **™**M 2□ F 53 Director <u>213-66-2095</u> 09/24/1954 Washington, D.C. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f short must be notified at 1 <del>XX</del>es 2 □ No Directo Maryland | Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12407 Sarah Lane 20715 U.S.A. Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Item 27 Is marked other than "natural", or Iter other traumatic event, the Medical Examiner Yes 2XNo f Yes, Give rear or Dates: 1XXNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify. þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk - Produce Giant Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie O. Lester Audrey N. Drye 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau once. Jane Martz/Sister 786 Match Point Drive, Arnold, Maryland 21012 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 01/15/2008 Burtonsville, Maryland 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical consequence of Examiner Sequentially list conditions it are, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Pag-II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 Wo 1☐ Yes or Attending Physician; To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and itle of contine 29d. Date signed (Month, Day, Year, 8118 GOODLUCK ROAD Name and addre

State Registrar

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			For State	State of Marylan					200		
		-1	Registrar  1. Decedent's Name (First, Middle, La.	st)	Ce	rtificate of	Deam	2. Date of De	Reg. No. 2	108	3. Time of Death
Е	Physici /Medic		Virginia Han	rrison N	Magnol	ia		Month Januar	Day 10, 2	Year 008	6:11p M
1	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Deat		4c. County		
	<u> </u>	4	557 Sawmill Lane 5. Social Security Number 6. S	Sex 7. Age (In yrs.	lact hirthday)	Crowns	sville   If Under 24 Hrs.	. 8. Date of Birl		Arund	le1 ace (State or Foreign
	Funeral Director			™ 2√2 F 83	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) L, 1924	Countr	ry)   <b>ini</b> a
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	ath wil	ral	557 Sawmill Lane			2.1	1032		USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces?  1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:		Was Decedent of HIF Yes, specify Cub 1 ☐ Yes 2 ☐ No X	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Blac	e - America ck, White, et White	tc.
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Maryland	nd 2 shou aith and M 27 is mar ir traumat		19a. Informant's Name/Relationship ( Mary Ann Judith	,		ng Address (Street 7032 Silv					
Baltimore,	Pages 1 and of Her of Her int; If item Iry or othe		20a. Method of Disposition  1	Removal from State	emetery, cre	osition (Name of matory or other pla eaven Cem		Date an. 14,		,	vn, State
Balti	permit. Departn Importa any Inju		21. Signature of Funeral Service Licer	nsee		2. Name and Addre rancis J. 00 Univer		Funeral	Home I	nc.	86 8
TOTAL STATE OF	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Cerebral Vas  Due to (or as a consequence)  b. Chronic Atri	n. Do not en  cular  uence of):	ter the mode of dyi	ng, such as cardia				Approximate Interval Between Onset and Death
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68760,	icate be executed physician and s the burial-transit	dical		d <u>General Debi</u>	lity						
P.O. Box (	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	у			te of delivery onth D	y Day Year
S, P	es that gned b	by Pt	Part II. Other significant conditions of	contributing to death but not resu	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	obacco use cont	ribute to the	e cause of death?
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	Hos 24 h Fur stely	Medical C	29a. Certifier 1 <sup>™</sup> Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of my kno niner: On the basis of examina and maniner stated.	wledge, deat tion and/or in	h occurred at the ti	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place,	inner as sta and due to	ited. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number 1978		29d. Date signed		
)	50		N	m. N.			1970		January	11, 4	2000
			30. Name and addr of person who Nader Tavakoli,			<sup>Print)</sup> /ille Roa	d, Bowie	, MD 207	16		
6	Sta Registr	_	31. Date filed (Month, Day, Year)  JAN 1 4 20	32 egtstrar's Signa	ture	artis					

		-	For State Of Maryla  State Registrar		rtificate of l			g. No.				
8	Dhysicis		1. Decedent's Name (First, Middle, Last)				2. Date of Deat	Day Year	3. Time of Death			
*	Physicia /Medic	al		ORE	at on T	L continue of Donath	Januar	4c. County of Deat	S 2038 M			
	Examin	C1	4a. Facility Name (If not institution, give street and number)			Location of Death						
	Funeral		Washington County Hospital  5. Social Security Number 6. Sex 7. Age (In yr.	s. last birthday)		rstown If Under 24 Hrs.	8. Date of Birth (Month, Day,	Washingto	DD COUDT Y hplace (State or Foreign untry)			
AL.	Director		217-30-5969 <sup>1</sup> XM <sup>2□</sup> F 74	4 Yrs.	Months Days	Hours Min.	Feb 20		ryland			
	pur .		Usual Residence of Decedent  10a. State 10b. County 10c. 0	City, Town or Lo	ocation				10d. Inside City Limits			
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	r dear	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White				
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 □ Yes 2 【X No	Specify:		Specify: Wh	nite			
Maryland 21215-0036	2 hou latura	ted	15. Decedent's Education	70	16b. Kind of Business/Industry							
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Ē	Pages Iment of I tant: If its jury or o		4 ☐ Donation 5 ☐ Other (Specify)		wn Mem Pa		-2008	Hagerstown	Maryland			
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.	. 11	21. Signature of Funeral Service Licensee	. 1	2. Name and Addre	До	_	. Fiery Fu				
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  1331 Eastern Blvd. N. Hagerstown Mary 1 and 217//2  Approximate Interval Between Onset and Death Onset and Death									
9.	Physician		Immediate Cause (Final									
	/Medical		disease or condition resulting in death)  Due to (or as a consequence of):									
þ	Examiner		Sequentially list conditions b.									
	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	equinos offr								
_	xecute and I-trans	Examiner	that initiated events resulting in death) Last  C  Due to (or as a cons	equence of):								
68760,	tificate be executed ig physician and as the burial-transit											
289	tificate g phy as the	ledical										
Š		an/N	IF FEMALE:   23b. Was decedent pregnant   23c. If yes, outcome pf pregnant   1 □ Live birth   2 □ F		□Ectopic pregnanc	y		23d. Date of de Month	livery Day Year			
Vital Records, P.O. Box	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	Physician/N	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	of death 5	Other (specify)			Monar	Duy Tour			
<u>Ч</u>	that thed by detack		Part II. Other significant conditions contributing to death but not r	esulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?			
ġ,	uires signe Id be	Completed by	Congestive heart t	gilura			1 □ Y	es 2□No 3☑P	robably 4 □Unknown			
S	w reg	lete					24a. Was a		utopsy findings available			
Re	The lav te has age 2	omp					autops perfor 1⊟ Yes	med? prior to death? 2☑No 1☐Yes	completion of cause of s 2□ No			
ital	stan: artifica ctor, p	Be C	25. Was case referred to medical examiner?			26. Place of Death		- 1				
× ×	Physician: r this certifica ral director, p	To	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2		ant JU DOX			ence 6 Other (Spe	ecify)			
Division or	ting P	ion:	27. Mann of Death  1. Natural 5 ☐ Pending (Month, Day Year, 2 ☐ Accident investigation	28b. Time ( Injury	Wo	ryat rk? ]Yes 2□No	28a. Describe n	ow injury occurred				
isi.	Attending r death. ector: Afte by the fune	ficat	3 Suicide 6 Could not be 28e. Place of injury - A	t home, farm, s				treet and Number or R	ural Route Number,			
<u>S</u>	alor/ s after Il Dire	Certification:	4 ☐ Homicide determined building, etc. (Spe	ecity)			City or Tow	n, State)				
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier  (Check only  2   Medical Examiner: On the basis of exam	knowledge, dea	th occurred at the ti	ime, date and place, opinion, death occur	and due to the o	cause(s) and manner a	s stated. e to the cause(s)			
	the H hin 24 the F rplete	Medical	one) and manner stated.  29b. Signature and title of certifier		29c. Licens			29d. Date signed (Mon				
	S S S	-	23b. Signature and title of Certainer					011.7	2008			
0	12		30. Name and address of person who completed cause of death (I	tem 23a) (Type	. Print)	05088		0,[17]	217117			
	/		NEAR PATALINGHAG, MD 1111	DOMEDK	te Ampus	CRD Sn/	TE 107	HAGERST	ann mb			
	Sta Regist		31. Date filed (Month, Day, Year) 32. Jegistrar's Si	gnature	book	SRD Sny						
	negist	-ar	LAN O LOU LARACTER		-C-01212121212							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** anuary 2008 /Medical 4c. County of Death Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WOSHINGEN CONIG pas 10 If Under 24 Hrs. 9. Birthplace Country) If Under 1 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) (State or Foreign **Funeral** Days Hours 1 ★M 2 □ F Director 215-64-0675 25. 1953 VIRGINIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 ☑ Yes 2 ☐ No Director WASHINGTON MARYLAND HAGERSTOWN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 21740 U.S.A. 50 SUMMIT AVENUE Funeral ural", or items 2 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 9 3 ☐ Widowed 4 ☑ Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical College (1-4or 5+) than Elementary/Secondary (0-12) 4 AUDITOR GOVERNMENT CONTRACTOR other item 27 is marked othe other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM TROY McKNIGHT DOROTHY ELAINE CROWL 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1-A CRESCENT ROAD, GREENBELT. JENNIFER A. LOGSDON/DAUGHTER MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any Injury or c 1 🔯 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) BROWNSVILLE HGTS. CEM 1/16/2008 | BROWNSVILLE, MARYLAND 22. Name and Address of Facility 21. Signat re of Fu 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland Part . Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to ( as a consequence of): Examiner ed Westion Sclive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown signed I Part II. Other significant conditions of ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes □ No 24a. Was an has e 2 autops page, perform certificate Division or Vital or Attending Physician: 25. Was case referred to medical examiner? After this certific funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA P 1 ☐ Yes 1 Inpatient 27. Nanper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the Funeral Director: npletely filled in by the 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours after To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 h 29d. Date signed (Mgnth, Day, Year) 29b. Signature and title of certifig

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Resistrar's Signature

Morestan, MD 8/747

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Ma	ryiand		tificate of			giene Reg. No.			
Phy	sicia	n	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	20 Vear8	3. Time of Death		
	edica	al .	David Lee Merson		01	07	2008	12:49 P. <sup>M</sup>					
Exa	mine	er	4a. Facility Name (If not institution, give 2561 Coon Club Re	4b. City, Town, o	r Location of Death Ster		4c. County of Death  Carroll						
Fune	rai		5. Social Security Number 6. S		(In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	1	9. Birtho	place (State or Foreign	
Direc			219-22-9726	Yrs.	Months Days	Hours Min.	06/16/	1929	Maryland				
and w			Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location         10									0d. Inside City Limits	
Maryla f sho	ופת מו	ō	Maryland Carroll		West	minst	er					1 □Yes 2X No	
r 28a		rec	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cour	itry?	
th wit 23a o	Ten l	Funeral Director	2561 Coon Club Ro	ad			21157			Uni	ted Sta	tes	
er dea		nue	11. Marital Status	12. Was Decedent E Armed Forces?		3. 13.	Was Decedent of H f Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	. 14	<ol> <li>Race - Americ Black, White,</li> </ol>		
356 Is after	Nation 1	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1√7 Yes 2 □ N If Yes, Give Year or Dates:	o WW]		1□Yes 2X No	Specify:		8	Specify: Wh	ite	
d 21215-0036 filled within 72 hours after death with the Maryland Hygiene. Hydrer than "natural", or items 23a or 28a-f show not the Marinal Evanting must be notified at		ted	15. Decedent's Ec	lucation	*****	16a. Dece	dent's Usual Occup	nation during most of work	dina	16b. Kind	d of Business/In	dustry	
Ind 21215-0 be filed within 72 ho ttal Hygiene. d other than "natu	D N	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	`life. I	DO NOT use retire	d)	ung	m 1 1 a			
filled w Hygier		ပ္ပြဲ	12 Supervisor  17. Father's Name (First, Middle, Last) 18. Mother's Name (						e (First Middle	Telephone Company (First, Middle, Maiden Surname)			
C e le c le c le c le c le c le c le c l	2	To Be	Unknown Annette I								,		
Maryland 2 Id 2 should be filed v Ith and Mental Hygie 77 is marked other i		<u>-</u>	19a. Informant's Name/Relationship (	Type. Print)		19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numbe	er, City or	Town, State, Zip	Code)	
			Charlene G. Knigh	t – Step-da									
S S S E			20a, Method of Disposition 1 → Burial 2 □ Cremation 3 □	Removal from State	CE	emetery, cirei	sition (Name of natory or other pla	ce) ¦	Date		ation - City or To		
Baltim permit. Pag Department Important:	, i		4 □ Donation 5 □ Other (Specif	1)	Mead		ge Memor:  2. Name and Addre	ial   1/11				Maryland	
Baltim permit. Pag Department Important: I	once	Į	21. Signeture of Fundral Service Licer		M0149	an l		LIL	ine Fune			4 South	
		+	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onest and Death										
Physician			Immediate Cause (Final disease or condition										
/Medic			resulting in death)  Due to (or as a consequence of):										
Examin	311	_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										
uted		Examiner	cause. Enter Underlying Cause (Ulsaase or injury that initiated events  c.										
68760, ificate be executed physician and	1,18	Exa	resulting in death) Last  Due to (or as a consequence of):										
68760 ficate be e		ledical		⊸d									
	ri I	/Me	IF FEMALE:	23c. If yes, outcome p	of pregnar	ncv				25	d. Date of deliv	on.	
death certifi		cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 4 ☐ Pregnant et	2 🗌 Fetal	death 3[	Ectopic pregnanc Other (specify)	у		2	Month	Day Year	
P.O.	200	Physician/M	9 Unknown	9□Unknown									
- E 0 2	5 0	by P	Part II. Other significant conditions of					ven in Part I.				he cause of death?	
Ord requir	Dino.	ted	Essentuelti	n Chr	<u>~~</u>	Reve		of the	)			oably 4 □Unknown	
e la	7 2	Completed	Revighed Varieten dez Nystyndenson							24a. Was an autopsy performed? 24b. Were autopsy findings availa prior to completion of cause death?			
	n, pa		25. Was case referred to medical					26. Place of Dea	1 Yes	2 ☐ No	1 ☐ Yes	2□ No	
ysicia is cert	Oli eco	o Be	examiner? 1 ☐ Yes 251 No	Hospital: 1 ☐ Inpatie	nt 2 🗆 E	ER/Outpatier	nt 3 DOA Oth	201	ome 5 AResid		□Other (Specia	fy)	
n Ol ng Ph fter th	<u> </u>	Ľ.	27. Manner of Death  18 Natural 5 Pending	28a. Date of Injur (Month, Day		28b. Time o	f 28c. Inju Wo		28d. Describe I				
SiO tendin eath. tor A		catic	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be					Yes 2 □ No	28f. Location (Street and Number or Rural Route Number,				
DIVISION Or VITA To the Hospital or Attending Physician: within 24 hours fler death. To the Funeral Director. After this certifics	à I	Certification:	4 Homicide determined	28e. Place of inju building, etc	ry - At noi :. (Specify	me, tarm, sti	еет, тастогу, опісе		City or Tov	street and vn, State)	Number or Hur	al Houte Number,	
spital	De la lace		29a. Certifier 1 Certifying Pr	ysician: To he best	my knov	vledge deat	n occurred at the ti	ime, date and place	, and due to the	cause(s) a	and manner as s	stated.	
he Ho in 24 h	a a a	edical	one)	niner: On the basis of and manner sta	examinat ted.	on another in			rred at the time,	date and	place, and due t	to the cause(s)	
		Σ	29b. Signature and title of certifier	// /	///		29c. Licens	se number		29d. Date	signed (Month,	Day, Year)	
MI			20 Name and address of several states	to N	ath (It	23a) /T	Print\	2794	1	40	N. 8-61	2008	
7+14	A		30. Name and address of parent who	molech	Dir	23a) (Type,	مالی کور	netho	M S.	\$	201	were to	
T-F	Stą	_	31. Date filed (Month, Day, Year)	32. Registre 2008	r's Signat	ture		V V	and the	-	4		
Reg	gistra	ar	JAN I 0	2008	que	J.	book						

DHMH 17 Rev 1/2001

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DHMH 17 Rev 172001

OCME

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arin Murray		-For State Amend Pten of Maryland, Despartment of Death and Mental Hylenstrar Certificate of Death	Reg	No. 200	18 0220
Physicia Medical Exami	ın/ ner	1. Decedent's Name (First, Middle, Last)  DAR: N LEVAR Murray	January 12,	Day Year 2008 4c. County of Deat	3. Time of Death 1419 hrs
		4a. Facility Name (if not institution, give street and number)  McCready Memorial Hospital  4b. City, Town, or Location of Death Crisfield		Somerset	ļ
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min		(MM/DD/YYYY) 9. Bi Fore C	irthplace (State or ign ountry) MD
any	-	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
<b>*</b>	5	MD Somerset Crisfield			1 Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Dire	10e. Street and Number 27123 Old State Road  10f. Zip Code 21817	10g	L.S.	
	Fune	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 1 Widowed 4 Divorced If Yes, Give Year 12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Sign Yes, specify Cuban, Mexican, Puerto		14. Race - Ame White, etc.	erican Indian, Black,
nours aff	ed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	work done	16b. Kind of Business	
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Correctional Office	SER-	Instit	I
21215-0036 hould be filed within 77 and Mental Hygiene. is marked other than tire event, the Medical	Be Co	17. Father's Name (First, Middle, Last)  George Murray III  Heler	e (First, Middle, Mi SuH		
imore, MD 21215-00; Pages I and 2 should be filed withinent of Health and Mental Hygiene. ant: If item 27 is marked other ti		19a. Informant's Name/Relationship (Type, Print)  Helen Murray  Mother  19b. Mailing Address (Street and Number or a 7133 Gld State Road	d Crisfie	10, MD 21	.817
Baltimore, ME bernit. Pages I and 2 s Department of Health an Important: If item 27 njury or other trauma		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  4 Donation 5 Other Specify:		20c. Location - City of	
Baltimo permit. Pag Department Important:		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility An 314 Couf ST. Crisfie	thoy E. W	an Funeral	Home
Physician /Medical Examiner		23a. Part I. Enter the Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries	or resurratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
_		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.			
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated counts resulting in death). Last			
be executed sician and urial - transit		events resulting in death). Last Due to (or as a consequence of):  d.	<u>-</u>	<del></del>	
O, e be executed ysician and burial - transi	edical	UNPENDED AMENDED		23d. Date of deliv	974
Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate I hin 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physimpletely filled in by the funeral director, page 2 should be detached for use as the broaders.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	ancy	Month	Day Year
P.O. Box es that the deatl igned by the att	y Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?
IS, P quires then en signe uld be d	ted by		1 Yes	n   24b. Were	autopsy findings available
of Vital Records, ng Physician: The law require the christicate has been si meral director, page 2 should b	Completed		autops perform 1 <b>V</b> Yes 2	med? death	
tal Rection: The certificate	Be	25. Was case referred to medical examiner? Hospital: Inpatient 2 FR/Outpatient 3 DOA Other4 Nurs			
of Vital Ing Physician: After this certif	မ	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred	her:
ion (tending leath. At the fur	ation	1 Natural 5 Pending Jan 12, 2008 1344 hrs 1 Yes 2 ✓ No			ntrol and ejected
Division  To the Hospiral or Atteudin within 24 hours after death.  To the Funeral Director: /	Certification:	3 Suicide 6 Could not be determined Could not be determined (Specify) Interstate/Express	or Town, St		Rural Route Number, City , Md.
To the Hospital within 24 hours To the Funeral completely filled	Medical (	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred	id due to the cause at the time, date a	e(s) and manner as s and place, and due to	tated. the cause(s)
To Wit	Mec	29b. Signature and title of certifier  29c. License number  O.C.M.E.		29d. Date signed (i	
		30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, I	MD 21201	L	
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regis		JAN 1 5 2008 Plane De April			
1/2		OCME ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Moxley, Charles W. 10, January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 854 Wilson Road Anne Arundel Arnold If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours 1√2 M 2 □ F Yrs. 1921 Maryland Director 215-14-0047 86 11, Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Directo Maryland | Anne Arundel Arnold 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 854 Wilson Road 21012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: ð 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien. Important: if item 27 is marked other the any Injury or other traumatic event the C&P Telephone, Co. Central Office Repairman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilson Margaret ပ Arthur Thomas Moxley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W. Moxley, Jr./ Son 858 Wilson Road, North, Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans 1/22/2008 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licente 22. Name and Address of Facility Brinsfield-Echols 30195 Three Notch Funeral Home, P.A. Rd., Charlotte Hall, MD 20622 M00817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) N0 **Physician** a /Medical Due to (or as a consequence of) Examiner ex Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of)

been signed by the attending physician and should be detached for use as the burial-transit the death certificate be executed Division or Vital Records, P.O. Box 68760.

Physician/Medical ģ Completed Be ဥ Certification:

cate has page 2 s

ai or Attending Physician:

To the Hospitai To the Funeral

Director:

Medical

State

IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 No Other: 4 ☐ Nursing Home 5 ☐ Nursing Hom 1 TYes 2 ER/Outpatient 3□ DOA

27. Manner of Death Natural 2 Accident 3 ☐ Suicide

4 Homicide

(Check only

29b. Signature and title of certifier

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury

1 Yeş 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 2008

28d. Describe how injury occurred

2008

23 55

Birthplace (State or Foreign Country)

White

10d. Inside City Limits

Approximate Interval Between Onset and Deat

Dav

Year

2106

1 ☐ Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AGADD

Registrar's Signature 31. Date filed (Month 2008 4

Registrar DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Huvnh T. Nguyen 2008 6:53 January 11, /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Olney Mont gomery Birthplace (State or Foreign Country) Montgomery General Hospital 5 Social Security Number 6. Sex If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🖺 F Yrs. 214-71-4614 68 1939 May 15, Director Vietnam Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Olney 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ō must be 'natural', or items 23a dical Examiner must t 3329 Megans Way 20832 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specific sian Completed by 3 Widowed 4 Divorced traumatic event, the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) <u>Homemaker</u> Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cu Nguyen Nguyen Thi Phan 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Health a Andy C. Le/Son-in-Law 3329 Megans Way, Olney, Maryland 20832 Department of Health Important: If item 27 any injury or other troonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Chua Son Long 2008 Qui Nhon, Vietnam 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. . Ken. 500 University Blvd, W. Silver Spring. MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ENCEPH ALOPATHY ANOXIC **Physician** 24 HOURS /Medical Due to (or as a consequence of): Examiner 24HOURS ACUTE ASTHMA Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 R No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perform 2 **2** No 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Minpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Box 68760. P.O. Division or Vital Records. Hospital or Attending Physician: filled in by 24 hours a within 24 hor To the Fune completely f

altimore, Maryland 21215-0036

1 Natural 5 Pending investigation 2 Accident 3☐ Suicide

6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

4 Homicide

29a, Certifier

Fr J. mage.

29c. License number 023630

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) JANUARY 11, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

FRANK J. MAYO, MO 16220 FREDERZCK RD, #213, GAZTHERSBURG, MARYLAND 20977

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

31. Date filed (Month, Day, Year) JAN 14



2

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Mildred Nurmi January 11, 2008 3:00 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Health Care College View Frederick Frederick Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Months 1 M 2 XF 87 Ohio Director 058-14-5707 September 9,1920 Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location 10d Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 Ves 2 No Director Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 2 Important: or other traumatic event, the Medical Examiner must be no once. 21702 United States 100 Burgess Hill Way Apt. 315 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Order Clerk Pharmacy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Henderick Nurmi Amanda Salo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Guhola / Niece 2103 Wayside Drive #2 Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State January 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 14, 2008 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Sign re o Funeral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician LEPHAIO disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Small if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9☐ Unknown 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 ☒ No 24a. Was an autopsy perform 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 After this after death. I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide l 🗹 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours a To the Funeral C

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Henren

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

			1_ For State	State of Ma	arylar					Mental Hy	giene	200	8	02208
			Registrar  1. Decedent's Name (First, Middle, Las.	*1		Cer	tificate	Of L	Jeath	2. Date of De	Reg. No			0. T/D
100	Physici			" Osi s	010	J				Month	Day	7 Č	å	3. Time of Death O2:24AM
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)	CIC		4b. City, To	own, pr	Location of Deat		4c.	County of D		000111
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	Funeral		Social Security Number     6. Se	7. Ag	e (In yrs.	last birthday)	If Under 1 Months	Year Days	If Under 24 Hrs Hours Min		1h			ice (State or Foreign
	Director		216-38-3863 Usual Residence of Decedent	J M ZLAF	67	Yrs.				July 8,	1940	) <u>M</u> a		land
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10	d. Inside City Limits
	Mary	ţ	Delaware Sussex Ocean View										1 ☐ Yes 2 📉 No	
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38	rs afte	y F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ 1 If Yes, Give Year or Dates:	No	1	☐ Yes 2	No X	Specify:			Specify:	Whit	-0
5-0036	within 72 hours after death with the Maryland ane. then "netural", or Iteme 23a or 28a-f ehow 'a Medical Examiner must be notified at	Completed by Funeral	15. Decedent's Edi			16a. Deced	ent's Usual	Occupa	ition		16b. K	ind of Busine		
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DOB C DOD C Baltimore,	permit. Pages Department of I Important: if It any injury or o		1 Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,		Par	emetery, crem k Hill	atory or oth Cemet	er place terv	<sup>9)</sup> Jan. 1	5, 2008	Mar	bury,	Mar	ryland
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	/Medical Examiner		resulting in death)	Due to (or as				r	,					
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	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		A 1 N-									
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	0 0 0	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at 9☐Unknown			Other (spec					Month		Day Year
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~ ~	Attending Physician: The lar r death. actor: Alter this certificate hes by the funeral director, page 2		27. Manner of Death  ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury		: Injury Work		28d. Describe			,,	
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ž	or Att	Ē	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ury - At ho c. (Specify	ome, farm, stre	et, factory, o	office		28f. Location ( City or To			Rural .	Route Number,
	Hospital		29a. Certifier Sertifying Phy	elejes. T. Ab. Link										
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	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier	/			29c. l	icense	number		29d. Dat	e signed (M	onth, D	ay, Year)
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	Sta Registr		JAN 1 4 200	8 2. Registra	ar's Signa	ture	K.		1					1

Certificate of Death

Albert William Pfaff

1. Decedent's Name (First, Middle, Last)

**Physician** 

2. Date of Death January 2008 10:24 AM 4c. County of Death Anne Arundel Birthplace (State or Foreign Country) 1924 Pennsylvania 10d. Inside City Limits 1 ☐ Yes 2√T√No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. White Specify: 16b. Kind of Business/Industry Pharmaceuticals 18. Mother's Name (First, Middle, Maiden Surname) Annapolis, MD 21401 20c. Location - City or Town, State Silver Spring, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 Approximate Interval Between Onset and Death 010145 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2∏ No 2 No 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) Parhway, annapolis, to

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of

1 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Paul Richard Perrell 1223 2008 /Medical Janvar 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours 10/23/1928 218-24-7535 79 WV Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Washington Fairplay 1 ☐ Yes 2 XNo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21733 8667 Jordan Road US Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2XNo Maryland 21215-0036 White 1 ☐ Yes 2 🛛 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Construction Dynamite Blaster 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adam Edward Perrell Bertha Carrie Mellott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ella M. Perrell / Wife 8667 Jordan Road, Fairplay, MD 21733 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1K Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 01/18/2008 Hagerstown, MD 21. Signatur — uneral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on jach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Wrig **Physician** /Medical Du to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examine burial-transit death certificate be executed Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. 9☐Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to cco use contribute to the cause of death? Records, þ Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ho page 2 certificate Division or Vital 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 3 No 1 Inpatient 2 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: Hospital or Attending 1 Natural 5 ☐ Pending investigation Injury within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

the 2

State Registrar 31. Date filed (Month, Day, Year) **JAN 17** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certified



29c. License number

027898

29d. Date signed (Month, Day, Year)

HAGERSTOWN, HD 21740

DHMH 17 Rev 1/2001

State

Registrar

WASUINGDA

BANMONE

JAN 1 0 2008

31. Date filed (Month, Day, Year)

			T- State of Maryland State of Maryland		artment of Hortificate of E			giene Reg. No. 20	08 02212			
			Decedent's Name (First, Middle, Last)			·	2. Date of Dea	ath	3. Time of Death			
A.	Physici /Medi		SEBASTIANA		RAM	IREZ-	Month		Year   13:51 P M			
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County o				
			Shady Grove Adventist Hospital		Ro	ckville		Mon	ntgomery			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8. Date of Birt (Month, Day	h v. Year)	Birthplace (State or Foreign Country)			
43	Director		216-61-4262 1□M 2XF 90	Yrs.	World Days	riouis wiii.		5, 1917	El Salvador			
	pu >		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Lo	nation				dod Inside City Limite			
	aryla shov d at	F	Too. County	TOWIT OF LO	cation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
	8a-f	Scto	Maryland Montgomery	Ro	<u>ckville</u>		-1					
	vith the	Ë	10e. Street and Number		10f. Zip Code			10g. Citizen of Wh	nat Country?			
	ath v	ra	4224 Landgreen Street			853			Salvador			
	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examiner must be notified at	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	Black	- American Indian, , White, etc.			
36	rs aft ", or camil	by F	1★ Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:		Yes 2□ No	Specify: Sa	lvadora	n Specify:	White			
8	hou tura	ed i	15. Decedent's Education	16a Deced	dent's Usual Occupa	tion		16b. Kind of Bus	iness/Industry			
21215-0036	in 72 n "na Aedic	Completed	(Specify only highest grade completed)	(Give life. l	kind of work done di OO NOT use retired)	uring most of worl	king		most, maddity			
7	within jiene.	E	Elementary/Secondary (0-12) College (1-4or 5+)	Homem	aker		,	Privat	t.e			
	i filed I Hyg other ent,	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Surname				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	To B	Patricio Ramirez			Antonia	Mercado	0				
ary.	should and Men s marke umatic	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rural Route N				umber, City or Town, State, Zip Code)				
	1 and 2 s Health ar tem 27 is		Rosa Ramirez/Daughter	4224	Landgree	n Street	, Rockvi	ille, MD	20853			
Ē,	s 1 a of Hea item othe		20a. Method of Disposition 20b. Pla	ce of Dispo	sition (Name of natory or other place	2)	Date	20c. Location - C	Dity or Town, State			
Ë	Page ent o nt: If ry or		T Bullat 2 Gerellation 3 Linethoval from State		itan Crema	atory Ja	n. 15,	Alexano	dria,Virginia			
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service Licensee	22	. Name and Address	s of Facility	008 L					
m	an per		De Garas SVIII	1	Francis J							
	- 44		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate  Approximate									
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final						Interval Between Onset and Death			
	/Medical		disease or condition resulting in death)  a. Due to (or as a conseque						hats			
	Examiner	Jer	ON ELIM						\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\			
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		1				30,45			
	icate be executed physician and s the burial-transit	Examiner	that initiated events	COLT	IS OF RE	CTOSIA	0100	days				
o,	execan ar	E	resulting in death) Last Due to (or as a conseque	nce of):								
68760,	rte be ysicia ne bu	dical	d									
	rtifica ng ph as th		IF FEMALE.									
Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	by Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal of		Ectopic pregnancy			I	of delivery			
m	dear death	Sicie	1 Yes 2 No 4 Pregnant at time of dea		Other (specify)			Mont	th Day Year			
P.O.	at the by the	μ̈́	9 ☐ Unknown									
S,	es tha	by F	Part II. Other significant conditions contributing to death but not result	ing in the ur	nderlying cause give	n in Part I.	23e. Did to	obacco use contribute to the cause of death?				
ğ	w requir been si should	ed	SUPRAVENTRICULAR TACH	TACK	LOIA		1 D Y	/es 2X No 3	3 Probably 4 Unknown			
Records,	law r as be 2 sh	Completed	CHRONC BRONCHITIS				24a. Was a	an 24b. W	ere autopsy findings available for to completion of cause of			
	<b>nysician:</b> The law nis certificate has t I director, page 2 s	mo.	DINEDTES MELLITUS:	CV PI	2.2			rmoed? de	eath?  Yes 2 No			
Vital	sian: ertific etor,	Be (	25. Was case referred to medical examiner?	- ( )		26. Place of Dea		/\	7			
2	nysic nis ce I dire	일	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ El	R/Outpatien	t 3 DOA Other	r: 4 Nursing He	ome 5 Resid	dence 6 Dother	r (Specify)			
0	Attending Physician: r death. ector: After this certifics by the funeral director, p	Ë	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury Work	at ?	28d. Describe h	now injury occurre	d			
Division or	endinath.	atic	2 Accident investigation			es 2 □ No						
ž	irect irect	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (S		r or Rural Route Number,			
	ital or ris affinal or ral D	Ce										
	Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	ledical	29a. Certifier (Check only one) (Check	edge, death on and/or in	n occurred at the tim vestigation, in my op	e, date and place inion, death occu	, and due to the or rred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)			
	To the Hospital or Atten Within 24 hours after death To the Funeral Director: completely filled in by the	Mec	29b. Signature and title of certifier		29c. License	number		29d. Date signed	(Month, Day, Year)			
	/		Van X/X X/ALL IN		Do	0 6583	30	JAMPRY	11. 2008			
,	5		30. Name and address of person who completed cause of death (Item 2	3a) (Type								
			JAMIE P. MODANO, M		201 MEDICA	L (#N)	ER DR	Rexx	IE M DORCO			
7%L	Sta	te	31. Date filed (Month, Day, Year) 32. gistrar's Signatu	re	0		1	1-1016	1-1-1 20010			
	Registr	ar	JAN 14 2008 A	S do	act o							

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** January 10 Betty J. Robertson 2008 0145 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Nov 05 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🙀 F 1924 83 321-20-3274 **Director** ILL Usual Residence of Decedent the Maryland 10c. City, Town or Location la or 28a-f show t be notified at 10b. County 10d. Inside City Limits 1 XYes 2 No Directo Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 College Avenue ms 23a 21776 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status "natural", or item edical Examiner r Black, White, etc. ☐ Yes 2 Mo Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify. þ Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Clerk Public Library 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental fitem 27 is marked or r other traumatic eve Charles R. Aulabaugh Eliza R. Bullard ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Darrell Robertson, Jr/son 279 Stem Road Union Bridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages of the Department of the Important: If ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State All\_Saints Cemetery 1/12/2008 Reisterstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Pritts funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) detached 9 Unknown þ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? be Completed 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page 2 autopsy certificate Division or Vital 1□ Yes 2 director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 \sum Nursing Home 1 🗌 Yes 22 No Hospital: this ို 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? After 28b. Time of Certification: 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 2 Medical Exami 29b. Signature and title of certifier 29d. Datersigned (Month, Day, Year) 3001 WJL 15 30. Name and addre persoη who completed cause of death (Item 23a) (Type, Print) OUSU 31. Date filed (Month, Day, Year) ar's Signature State **JAN 14** Registrar 2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year Virginia Estelle Rosen 0400 2008 January 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hospice Dove House Carroll Westminster if Under 1 Year | if Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Mar 03 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 D € 225-24-9045 83 VA Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 □ No Director MD Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or ms 23a 1000 Weller Circle 21158 USA Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian "natural", or Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be nd Mental I George Hannah Elcan Margaret Virginia Gilliam 흔 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Bair/daughter 108 Willis Street Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 01/16/2008 1 ☐ Suriai 2 ☐ Cremation 3 🖾 Removal from State ö Department of Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Buckingham Community Cemetery Buckingham, Virginia 22. Name and Address of Facility Pritts Funeral Home and Chapel, P.A. 21. Signature of Funeral Service Licensee 412 Washington Road Westminster, MD Approximate interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final METHICIlliw resistant STAPH MUREM SESSI Physician Jueck disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 Z No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ FALLIRA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Hother (Specify) 212 No 1 Yes 2 ER/Outpatient 3 DOA ٩ 1 Inpatient this To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral. 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Alatural 2 Accident 5 Pending investigation 1 Tes 2 No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Registrar

State

WIL

5

29a, Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

STOMATIKE

**JAN 1 4** 

enno U-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

GALVW

Medical

DHMH 17 Rev 1/2001

**ORIGINAL** 

in

III MO

32. Regitrar's Signature

16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

SEWER AVENUE

29d. Date signed (Month, Day, Year)

Wesoman stea, many la

21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 6/2008 4:15amM Albert Michael Smith **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Examiner 01ney Montgomery General Hospital 9. Birthplace (State or Foreign Country) PA 8. Date of Birth (Month, Day, Year) 4/6/1926 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Months Days Hours **Funeral** XXM 2 F 165-24-9828 81 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County 1 ☐ Yes 2 ☐ No 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, t<u>he Medical Examiner must be notified at</u> Silver Spring MD Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20906 3459 Chiswick Ct. Funeral 14. Race · American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 11. Marital Status Affiled Forces?

1 A Yes 2 No WWII

If Yes, Give
Year or Dates: White 1 ☐ Never Married 2 Married 1 ☐ Yes XX No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16h Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within all and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Dept of Defense Geodicist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Coury Albert Charles Smith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health an
Important: If item 27 is any Injury or other Silver Spring, MD 20906 3459 Chiswick Ct. Wife Dorothy Jean Smith 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State 1/9/2008 Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 Ridgely Ave. Annapolis, MD 21401 Galw 23a. Part1. Enter the disase, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Physician Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-trar Due to (or as a consequence of): attending physician for use as the burial pe Physician/Medical 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year 1 Live birth in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No signed by the a 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Rmal Failure 24a. Was an autopsy performed 2 No 26. Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No 1 Thipatient Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No М of Funeral Director: At sleep the Funeral Director: At sleep tilled in by the funeral filled in by the funeral tilled in 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 3 ☐ Suicide 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

within 24

To the Foundation

3altimore, Maryland 21215-0036

Box 68760,

P.O. 1

Division or Vital Records,

31. Date filed (Month, Day, Year) State JAN 1 0 2008 Registrar

29b. Signature and title of certifier

Churco Jacknes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher J. Mays, mis 18111 Paince & hilip & Olnay, mo 32. Pegistrar's Signature

29c. License number

D39793

29d. Date signed (Month, Day, Year)

January 6, 2008

DHMH 17 Rev 1/2001

State

Registrar

JUL 02

altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 08:39 15 George Allen Sites Z008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washinton County Washington County Hospital Hagerstown ear | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Virginia 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ F Director 224-52-6566 70 Nov 18 1937 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.
Is marked other than "natural" ar them. 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show cdcal Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11702 Robinwood Drive 21742 12. Was Decedent Ever in U.S. Armed Forces?

1 ∑ Yes 2 □ No 1 Yes, Give 2-19 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: <u>ک</u> Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: 2-1960 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Mfg. 12 Cloth Cutter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Sites Mary G. Moten Sites Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11702 Robinwood Drive Hagerstown Maryland 21742 Dorothy L. Sites - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or 1-17-2008 | Smithsburg Maryland 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee Kartlin affaron 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, a mplical ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocaloire INFARCTION /Medical Due to (or as a consequence of): Examiner RESPIRATION 5 HOYT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the burial-transi Pulmonne Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, GANGRE Physician/Medical TOF IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062006 1/151 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGTAKO-WIREDA STAGERITOWN ENT ANTIETAM ST. 31. Date filed (Month, Day, Year) 32. Restrar's Signature State

Registrar

JAN 1 8 2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State State Registrar	Cer	tificate of L			leg. No.	008	02219
P	hysicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	JAMES STAYMATES  4a. Facility Name (If not institution, give street and number)		4b, City, Town, or	Location of Death	JAN	4c. Coun	2008 ty of Death	0552 M
	examin	C1		Center	Baltmor					
	neral ector		220-54 <b>-</b> 2679 <sup>1</sup> <b>⋈</b> м ₂□ F	(In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 27	r, Year)	Coul	place (State or Foreign ntry) nsylvania
and	M 4		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	cation					10d. Inside City Limits
Maryl	rf sho	tor	Maryland Baltimore	Upperco						1 □ Yes 2 💢 No
th the	or 282 e noti	Direc	10e. Street and Number		10f. Zip Code			10g. Citizen o		
ath w	s 23a nust b	leal	5506 Bortner Road		21155	ionania Origin? (Par		Jnited	State	
paritimore, interpretation 21213-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	al", or item Examiner n	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Evarred Forces?  1 □ Yes 2 ☑ Note If Yes, Give Year or Dates:		vas Decedent of Hi f Yes, specify Cuba I □ Yes 2 No	ispanic Origin? (Spanic Origin?) In, Mexican, Puerto Specify:	Rican, etc.)	ВІ	ack, White,	etc.
72 ho	natur dical E	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa	ation during most of worki	ing	16b. Kind of	Business/In	ndustry
within ene.	than the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+	) [	cial Plar	•		Financ	ce	
e filed Il Hygi	other ent, ti	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,			
Vial be wild be Menta	arked tic ev	To B	Arthur Kistler Staymates			Maria Ho	<u> </u>			
2 sho	'Is me		19a. Informant's Name/Relationship (Type. Print)	l l		and Number or Run				
1 and Health	em 27 ther t		Saundra Stamboni Staymates/v 20a. Method of Disposition	20b. Place of Disposementery, crem	Bortner	ROAG (	Jpperco,	20c. Location		
Dalumor Dermit. Pages Department of	rtant: If It njury or o		1	Hampstead			008 Line Fur			Maryland
perm Depa	any ir		Slan C Turrin			Main Str				ryland 21074
/Me	sician edical miner		Due to (or	ment elevations equence of:  bran injured sequence of:	HON myor			rest,		Approximate Interval Between Onset and Death
do oo, oo, rificate be executed	physician and s the burial-transit	ledical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	consequence of):						
<b>₽</b>	To the Funeral Director: After this certificate has been signed by the aftending p completely filled in by the funeral director, page 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	/			Date of deliv	very Day Year
rus, r	n signed b uld be deta	by	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause giv	en in Part I.		obacco use co ⁄es 2□ No		the cause of death? bbably 4 □Unknown
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JIVISION OF VILA  I or Attending Physician: after death.	: After this o	မှ	1	/ 28b. Time of	f 28c. Injur Wor	4 🗆 Nursing 🗝	ome 5 Residence 128d. Describe h			ify)
DIVISION OF The Hospital or Attending F within 24 hours after death.	al Director	Certification:	C Could set be	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (5 City or Tov		mber or Ru	ral Route Number,
the Hospit in 24 hour	the Funer	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner stat	examination and/or in	vestigation, in my o	opinion, death occur	red at the time,	date and place	e, and due	to the cause(s)
		Σ	29b. Signature and title of certifier		29c. Licens			29d. Date sig		
WJ			30, Name and address of person who completed cause of de	ath (Itam 22a) (Tuna		83361		JANUA	Ry 5	2008
104	- (0			ath (Item 23a) (Type,		22 5. (	etreene S	+ Be.11	nmore	MD 21201
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registral	r's Signature		1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** BETTY JANUARY LORAINE STEVENS 2008 4:29A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🗓 F Director 217-32-7033 Jan. 15, 1936 West Virginia Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Y☐Yes 2☐No be notified Directo Maryland Frederick Brunswick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a "natural", or items 23a 1055 Peach Orchard Lane 21716 Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygene. and: If Hear 27 is marked other than "natural", or items 23 and: If Hear 27 is marked other than "natural", or items 23 ury or other traumatic event, the Medical Examiner must Funeral United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: White 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Henry Fraley Nettie Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is many injury or other traum Raymond Stevens / Son 1055 Peach Orchard Lane, Brunswick, MD 21716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 1/15/2008 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 au Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician C /Medical Due to (or as a considuence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 No 9 ☐ Unknown 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed?

1 Yes 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No 2 KR/Outpatient 3 DOA Certification: To 1 Inpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only and manner stated.

within 2

MD052890 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

2008

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		Registrar			Tillicale of D	ealli	2. Date of Dea	Reg. No. 🛶 💆	00	U 2 8 8
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Attending Physician: r death. ector: After this certifics by the funeral director, p	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant condition  25. Was case referred to medical examiner? 1 □ Yes 2 □ No  27. Manner of Death 1 ☒ Natural 5 □ Pending	Hospital:  2 Fe 4 Pregnant at time of 9 Unknown  1 Inpatient 2  28a. Date of Injury (Month, Day Year)  tion t be 28a. Place of Injury - 4t	esulting in the understanding	Other (specify)  Inderlying cause giver  Int 3 DOA Other  Int 28c. Injury Work?  M 1 Y	26. Place of Deat  4 □ Nursing Ho  at  es 2 □ No	24a. Was autoju perficulture de la compensación de	obacco use cor  Yes 2 No  an 24b  ssy  rmed? 2 No  dence 6 Or  now injury occu  Street and Num	ntribute to the stribute to th	Day Year  ne cause of death?  pably 4 2 Unknov  posy findings availate of cause of 2 No
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Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certifica tely filled in by the funeral director, t	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year) tion t be ed 28e. Place of injury - At building, etc. (Spe	esulting in the understand the substantial death significant in the understanding in the unde	Other (specify)  Inderlying cause giver  Int 3 DOA Other  Of 28c. Injury Work?  M 1 Yoreet, factory, office	26. Place of Deat  4 □ Nursing Ho  at  es 2 □ No  e, date and place, inion, death occur	24a. Was autoperficient of the control of the contr	obacco use cor  Yes 2 No  an 24b  say  rmed? 22 No  dence 6 On  now injury occu  Street and Num  vn, State)  cause(s) and n  date and place	ntribute to the stribute to condeath?  I were autorated the stribute to condeath?  I were stribute to the stri	Day Year  The cause of death?
ding Physician: ). After this certification funeral director, p	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	Hospital:  2Ba. Date of Injury (Month, Day Year) tion t be ed  2Be. Place of injury - At building, etc. (Spe  Physician: To the best of my k xaminer: On the basis of exami and manner stated.	esulting in the understand the second	other (specify)  Inderlying cause giver  ont 3 DOA Other  of 28c. Injury Work?  M 1 Y  reet, factory, office  th occurred at the time nvestigation, in my op  29c. License	26. Place of Deat  4 Nursing Ho at es 2 No e, date and place, inion, death occur	24a. Was autoperfice to the control of the control	obacco use cor  Yes 2 No  an 24b  ssy  ymmed? 2 No  dence 6 On  now injury occu  Street and Num  yn, State)  cause(s) and n  date and place	ntribute to the stribute to th	Day Year  The cause of death?
Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certifica tely filled in by the funeral director, t	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	Hospital:  2Ba. Date of Injury (Month, Day Year) tion t be ed  2Be. Place of injury - At building, etc. (Spe  Physician: To the best of my k xaminer: On the basis of exami and manner stated.	esulting in the understand the second	other (specify)  Inderlying cause giver  ont 3 DOA Other  of 28c. Injury Work?  M 1 Y  reet, factory, office  th occurred at the time nvestigation, in my op  29c. License	26. Place of Deat  4 Nursing Ho at es 2 No e, date and place, inion, death occur	24a. Was autoperfice to the control of the control	obacco use cor  Yes 2 No  an 24b  ssy  ymmed? 2 No  dence 6 On  now injury occu  Street and Num  yn, State)  cause(s) and n  date and place	ntribute to the stribute to th	Day Year  The cause of death?
Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certifica tely filled in by the funeral director, t	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	Hospital:  2Ba. Date of Injury (Month, Day Year) tion t be ed  2Be. Place of injury - At building, etc. (Spe  Physician: To the best of my k xaminer: On the basis of exami and manner stated.	esulting in the understand the second	other (specify)  onderlying cause giver  28c. Injury Work?  M 1 7.  reet, factory, office  th occurred at the time restigation, in my op  29c. License  OLE 9	26. Place of Deat  4 Nursing Ho at es 2 No e, date and place, inion, death occur	24a. Was autoperfice to the control of the control	obacco use cor  Yes 2 No  an 24b  ssy  ymmed? 2 No  dence 6 On  now injury occu  Street and Num  yn, State)  cause(s) and n  date and place	ntribute to the stribute to th	Day Year  The cause of death?

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Deeth Year **Physician** William William Paul Sears 01 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner enter Allegany Cumbelland Manur Health Cale 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** 234624499 Year) Days 12M 2□ F Keyser, WV Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-1 show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No W Director Mineral 1 4 1 Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1570 Terri Street USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or hear any injury or other transmitted. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Sheet Metal Elementary/Secondary (0-12) College (1-4or 5+) Fabrication Saw Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Paul William Sears Edith Faye Troutman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheri Lou Sears/ Wife 1570 Terri Street Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State Potomac Memorial Gardens Jan. 13 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examine OPROVED BY MEDICAL EXAMINER the attending physician and hed for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760 en CERTIFICATION Physiclan/Medical Due to (or as a consequence of) resulting in death) Last 23b. Did tobecco use contribute to the ceuse of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 2 → Yo 3 ☐ Probably 4 ☐ Unknown ð 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: ↓ ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes -ex Certification: To 27. Manner of Death 1. ■ Natural 2 □ Accident 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending death. 1 Yes 2 No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Lettilying Physician: To the best of my knowledge death occurred at the time date and sloce and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier en 10, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 912 N2+1 Huy LIVILLE AJTUllino 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

# 23 act Inco

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	epartment of Health and N Certificate of Death	Mental Hygi	ene	
			- negistiai	erinicale of Death	Re 2. Date of Death	g. No. 2008	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last)		Month	Day Year	M
	/Medic	14/5	Jane Herr Towle  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Jan 10.	4c. County of Death	3:30pm <sup>™</sup>
	Examin	er					
38		-Sa	Suburban Hospita1  5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	Bethesda Hay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgome 9. Birth	nplace (State or Foreign
ŀ	Funeral Director		014-14-3944 1 M 2 F 93	Months Days Hours Min	(Month, Day, Sept 20	Year) Cou	intry) nnsylvania
	70		Usual Residence of Decedent		Dept 20	1)14   161	
	rylan- how at		10a. State 10b. County 10c. City, Town of	r Location			10d. Inside City Limits
	e Ma ta-f s	턍	MD Montgomery Potoma	ıc			1 XYes 2 No
	or 28	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	untry?
	ath w	Funeral	11215 Seven Locks Rd #320	20854		Jnited Stat	
	tems	nue	Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sport of Yes, specify Cuban, Mexican, Puerly</li> </ol>	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
36	s afte	by F	1  Never Married 2  Married 1  Yes 2  No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: L	White
21215-0036	be filed within 72 hours after death with the Maryland ttal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Merical Examiner must be notified at	8	15 Decedent's Education 16a D	ecedent's Usual Occupation	1	   16b. Kind of Business/	ndustry
5	in 72 " ra le ic	Set	(Specify only highest grade completed)	Give kind of work done during most of wor fe. DO NOT use retired)	king		,
77	with jene r thai	Completed	Elementary/Secondary (0-12) College (4 <sup>4or 5+)</sup>	omemaker		Home	
b	other other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, M	flaiden Surname)	
<u>a</u>	Jid be Jenta rked ric ev	To E	Benjamin B. Herr	Leah Ba	rd		
Maryland	shool s ma s ma		19a. Informant's Name/Relationship (Type. Print)	ailing Address (Street and Number or Ru	ıral Route Number,	City or Town, State, Z	ip Code)
Σ	and 2 salth n 27 l			White Rose Way, E			
altimore,	of Ho		1 Rurial 2 V Cremation 3 Removal from State	isposition (Name of crematory or other place)		20c. Location - City or	
Ĕ	Pag ment ant:		4 □ Donation 5 □ Other (Specify) Nation		3-08	Falls Chui	-
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Jo 5130 Wisconsin Ave			
_	20 = 8 O		11 all display				
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)  Pneumonia				
	/Medical Examiner		Due to (or as a consequence or)				
		-	Sequentially list conditions, if any leading to immediate  b. Bacteremia  Due to (or as a consequence of)	:			
	nsit	Examiner	if any, leading to immediate Cause (Disease or Injury that initiated events  C.				
,	execu n and ial-tra	Exal	resulting in death) Last C. Due to (or as a consequence of)	•			
8760,	cate be executed physician and the burial-transit	dical	d				
9	tificat ig phy as th	ledi					
Вох	endin	N/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy		23d. Date of deli	,
Θ.	ed for	by Physician/Me	1 ☐ Yes 2 🗓 No 4 ☐ Pregnant at time of death	5 Other (specify)		Month	Day Year
P.O.	at the I by the	Ph S	9 Li Onknown		no- Didash		4
	The law requires that the death certific to has been signed by the attending to agge 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		acco use contribute to	obably 4X Unknown
ord	w requir been si should I	ted			1 1	5 2 NO 3 FI	DDADIY 4 TOTIKIOWII
ec	law lasb	nple			24a. Was ar autops	y prior to d	topsy findings available completion of cause of
E	: The	Completed			perform 1□ Yes 2	ned? death? No 1 ☐ Yes	2□ No
Vita	lcian Sertifi ector	Be	25. Was case referred to medical examiner?  Hospital: Was a Case of the case o	Othor	ath (Check only one	e)	
or	Phys this a	은	1		lome 5 Reside	nce 6 Other (Spec	cify)
n	ding J. After funer	ioi	1 Natural 5 □ Pending (Month, Day Year) Inju		20d. Describe no	w injury occurred	
Division or Vital Records,	Attending Physician: r death. ector: After this certific by the funeral director, I	icat	3 Suicide 6 Could not be 28e. Place of injury - At home, farm		28f. Location (Str	reet and Number or Ru	ıral Route Number,
<u>&gt;</u>	lor A after Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	City or Town		
_	lospita hours uneral		29a. Certifier #D Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place	I e, and due to the ca	ause(s) and manner as	stated.
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/ and manner stated.	or investigation, in my opinion, death occu	urred at the time, da	ate and place, and due	to the cause(s)
	To the H within 24 To the F complete	M	29b. Signature and title of certifler	29c. License number		9d. Date signed (Monti	
1	25		5. wilks	D0063195		Jan 11,200	8
0			30. Name and address of person who completed cause of death (Item 23a) (Ty		`		
			S. Wilkes, M.D. 8600 Old Georget  31. Date filed (Month, Day, Year)  32 Registrar's Signature	own ra, betnesda, Mi	,		
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 1 4 2008  32 Registrar's Signature	houte			

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 9, 2008 **Physician** 1:10 PM Theresa Tesoro /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Bayside Care Center Lexington Park If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛛 F 089-22-4697 78 New York 1929 Director July 5. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1√□Yes 2□No Director Maryland St. Mary's Lexington Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be U.S.A. 14. Race - American Indian, Black, White, etc. 21711 Sartoga Drive 20653 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Statistical Typist Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be flik Department of Health and Mental Hy Important: If item 27 Is marked other any injury or other traumatic event Be Raymond Tesoro Anna <u>Tesoro</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Kreul / Niece 46708 Midway Drive, Lexington Park, Maryland 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. St. Mary's Cem. 01/18/2008 | Flushing, New York 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service licensee 3035 Old Washington Road M01246 Vask Huntt Funeral Home Waldorf, Maryland 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician aranomatos /Medical Due to (or as a consequence of): Examiner ncreatiz Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and the detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ 1√10 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Hatural 5 Pending 1 ☐ Yes 2 ☐ No

The law requires that the death certificate be executed P.O. Box 68760. Division or Vital Records, or Attending show

72 hours after death

should be filed within 7 and Mental Hygiene.

marked other than "n

Baltimore, Maryland 21215-0036

investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address-of person who completed cause of death (Item 23a) (Type, Print)

24035

State Registrar

Arhana (sup 31. Date filed (Month, Day, Year)
JAN 1 4 2008 32. Registrar's Signature

this

after death

thin 24 hours at Hospital

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Anita Faye Weaver 2008 anvar /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) Maryland Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M 2 🛛 F January 19,1934 Director 214-32-3994 73 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1X Yes 2 No Director Hagerstown Maryland | Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 906 Kenwood Drive 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 □ Yes 2 No If Yes, Give 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John William Obitts Mary Isabelle Shives ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Weaver - Husband 906 Kenwood Drive Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 X Burial 2 □ Cremation 3 □ Removal from State Riverview Cemetery Jan.18,2008|Williamsport,Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Osborne Funeral Home, P.A. 125 S.Conococheague St. Williamsport, MD 21795 21. Signature of the IS Med Consider por Mille 425 S.Conococheague St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician STROKE EMBOLIC O DAYS /Medical Due to (or as a consequence of) Due to (or as a consequence of): YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner YEARS ALTERIO SCLEROTIC KEHAT Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner The law requires that the death certificate be executed physician and s the burial-trans Box 68760. Division or Vital Records, P.O. signed by ti certificate To the Hospital or Attending Physician: neral Director: , filled in by the f within 24 hours at To the Funeral Completely filled i

Pages 1 and 2 should be filed within 72 hours after death with the Maryland anent of Heatth and Mental Hyglene. The marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 1/2001 4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Willen, MD

COKEN,

JAN 1 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

Medical

State

6. ANTIETAM

istrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0001040

HAGERSTOWN,

29d. Date signed (Month, Day, Year)

01-17-2008

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	aryland /	-	artment of F <i>tificate of</i>		Mental Hygid	ene () ( ı. No.	)8	02226
			Decedent's Name (First, Middle, La	st)				D Out.	2. Date of Death			3. Time of Death
н	Physici /Medio		Lewis Edison	Wolford					Month January	Day 16 2	Year 008	10:58 A M
	Examin		4a. Facility Name (If not institution, given				4b. City, Town, o	r Location of Death		4c. County		
			10916 Stuart Dri					iamsport	· · · · · · · · · · · · · · · · · · ·			ington
	Funeral Director			Sex 7.Ag NXSKM 2□F	e (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )			place (State or Foreign ntry)
			234-38-7586 Usual Residence of Decedent		80				June 6,1	927	West	Virginia
	nyland how		10a. State 10b. County	-	10c. City, Tov	wn or Lo	cation					10d. Inside City Limits
	Ba-f s	cto	Maryland Washi	ngton			Williams	sport				1 ☐ Yes 2 No
	vith th	Dire	10e. Street and Number				10f. Zip Code		100	g. Citizen of W	/hat Cou	ntry?
	ss 238	erai	10916 Stuart Dri	VE 12. Was Decedent	Suprim II C	12 1	Mac Decedent of h	21795	posify Vos or No	14 Page	USA	can Indian,
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Itams 23a or 28a-f show ant, Itat Medicul Exarch at resist te rediffed at	by Funeral Director	11. Marital Status 1 ☐ Never Married 3€ Married	Armed Forces?		- 1		lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		k, White,	
98	ali, o	by	3 Widowed 4 Divorced	1XXYes 2 ☐ 1 If Yes, Give Year or Dates:	1945	1	I □ Yes 2√XNo	Specify:		Specify.		hite
21215-0036	72 hc	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	168	. Deced	lent's Usual Dccup	ation during most of work	sina 16	b. Kind of Bu		
2	within ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5	+)			during most of work d)				
2	illed v Hygie ther t nt, in	Co	12 17. Father's Name (First, Middle, Last	)		_Pur	chasing		e (First, Middle, Ma	eating		lesale
au	d be d ental	To Be		Wolford					ladys Re			F.3
Maryland	shoul and M amari	ř	19a. Informant's Name/Relationship		19	b. Mailin	g Address (Street		al Route Number, (			
ž	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic evant, it at Medical Exactling trausities rediffed at once.		Frances Wolford	- Wife	10	916	Stuart [	rive Wil	liamsport	. Marv	land	21795
altimore,	es 1 a of He of He fitam		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐		20b. Place	of Dispos	sition (Name of natory or other place			c. Location -		own, State
Ĕ	Pag ment ant: b		`4 ☐Donation 5 ☐Other (Speci	<i>(y)</i>	Tuscaro	ra Pr	esby. Ch.	Cem. Jan.1	9,2008 Ma	artinsb	ourg	Virginia West
Bait	ermit. lepart nport ny inj		21 Signifure of Furer I Awice Lice	nsee		02	Name and Addre	ss of Facility Hou	me, P.A.			
	70 7 8 0		Jamasa	Para Alana Alana	N - 4-10 B	42	25 S. Cor	nococheag	ue St.Wil	liamsp	ort.	
			23a. Fart1. Enter the disease, or comshock, or heart failure. List only	one cause on each lir	the death. Do	not ente	er the mode of dyir	ig, such as cardiac	or respiratory arres	t,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Atheros								YEARS
	Examiner			Due to (or as	a consequence	of):	Va /1					Version:
		Jer	Sequentially list conditions, Tarry, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Use to (or as	a nonsequence	off:	460				=	1010
	cuted nd ransit	amir	uiat initiated events	с.								
Ö,	e exe	EX	resulting in death) Last	Due to (or as	a consequence	of):					- 1	
68760,	ficate be executed physician and is the burial-transit	edicai Examiner		_ d							-	
_	certifii ding I se as		IF FEMALE:	23c. If yes, outcome	of pregnancy					22d Date	o of dolin	00/
Box	The law requires that the death certii ate has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal deat		Ectopic pregnancy Other (specify)	/		23d. Date Mor		Day Year
P. O.	the d by the ached	hysi	1 Yes 2 No 9 Unknown	9□ Unknown			.,,,,,					
	s that pned t e det	by P	Part II. Other significant conditions	contributing to death b	ut not resulting	in the ur	nderlying cause giv	en in Part I.	23e. Did toba	cco use contr	bute to t	he cause of death?
ğ	aquire en siç ould b	per							1 🗌 Yes	2 🗹 No	3 🗌 Prol	bably 4 Unknown
ecc	law re as be	Completed							24a. Was an autopsy	24b. V	Vere auto	opsy findings available ompletion of cause of
= =		Соп							performe	d d	leath?	2□ No
Vital Records,	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Dth	OF.	h (Check only опе)			
o	Phys	٦.	1 ☐ Yes 2 ☑ No 27. Man r of Death	1 ☐ Inpatie		utpatien		4   Nursing no	ome 5 Residen			(y)
Division of	ding th: After	tion	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	Year)	Injury	Wor	k? Yes 2 □ No	Edd. Describe from	injury occurre	,,	
N S	Attanding Physician: or death. ector: After this certification in the funeral director. It	ifica	3 Suicide 6 Could not be determined	e 28e. Place of Inju		arm, stre	et, factory, office		28f. Location (Stre		er or Rur	al Route Number,
á	s afte at Dire	Certification;	4   Homicide	building, etc	L (Specity)				City or Town,	State)		
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best on the basis of and manner sta	examination a	e, death nd/or inv	occurred at the tir restigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and mai e and place, a	nner as s ind due t	stated. o the cause(s)
	To the To the comple	Me	29b. Signature and title of certifier	1 01			29c. Licens	e number	290	I. Date signed	(Month,	Day, Year)
2	N/2		Ha Home	1 11	751cc			0567	83 11	MAC	1)	1008
	5+1		30. Name and and essouperson who Jeffrey Hurwitz	completed cause of d				Rd Hago	rstown, M	Jarylan	d c	1742
	Sta		31. Date filed (Month, Day, Year)	32. Reastra	ar's Signature	aica	/ campus	Nu. Hage	ı Əı∪WII, IV	iai y i all	u Z	.1/44
	Registr	ar	JAN 1 8	2008	wa D	1	men -					

			For	State of N	Maryland /					and Me	ental Hyg	iene	201	10	0000
_		_	1 - State Registrar			Cei	tificate	of L	Death			g. No.	401	10	0222
в	Physici	an	Decedent's Name (First, Middle, La	_	*** 1	- 1					2. Date of Deat Month	Day	Ye Ye	ár.	3. Time of Death
1200	/Media	_	Roger	Lee		lade	41 O' T		1		January	_	2008 County of E		10:55a <sup>™</sup>
	Examir	er	4a. Facility Name (If not institution, given 11275 Fd and U-11		er)		4b. City, To			or Death			charle		
BC:	· F		11275 Edge Hill  5. Social Security Number 6.		Age (In yrs. last	birthday)	Newb		If Under	24 Hrs.	8. Date of Birth			Birthpla	ace (State or Foreign
	Funeral Director			<b>№</b> M 2□F	72	Yrs.	Months [	Days	Hours	Min.	8. Date of Birth (Month, Day, Feb. 22,	193	5	Count	ry)
343	PI .		Usual Residence of Decedent		1.0 01 7									140	d I - i de Oite I limite
	arylar show d at	<u>-</u>	10a. State 10b. County		10c. City, To									10	ld. Inside City Limits 1 ☐ Yes 2 No
	he M 28a-f otifie	ectc	Maryland Charl	es		Ne	wburg 10f. Zip C	ndo			1	Oa Citiz	en of Wha	t Count	
	with ta or 2	ä	11275 Edge Hill	Road				206	64			og. Omz	US		.,,.
	ns 23 musi	Funeral Director	11. Marital Status	12. Was Decede	nt Ever in U.S.	13.	Was Deceder	nt of Hi	spanic Ori	gin? (Spec	offy Yes or No-	1	4. Race - A	America	
ယ	or iter	F	1 Never Married 2 Married	Armed Force	s? No		lf Yes, specify 1 □ Yes 2€	y Cuba <b>∃k</b> No	n, Mexicar Specify:	n, Puerto F	lican, etc.)		Black, V	Vhite, e	tc.
03	ral", c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates	s:		ILLITES AL	ZIAO	эреспу.				Specify:	Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	1	6a. Dece	dent's Usual ( kind of work DO NOT use	Occupa done o	ation <i>Juring mos</i>	t of workin	g	16b. Kin	d of Busine	ess/Ind	ustry
121	within lene. than '	du	Elementary/Secondary (0-12)	College (1-4d	or 5+)						viation		NASA		
	12 should be filed w h and Mental Hygier 7 is marked other tt traumatic event, the	ပ္တို	17. Father's Name (First, Middle, Las			DIL	ector				(First, Middle, I	Maiden S			***
lan	id be ental ked o	To Be	Carl Donald	Winb1	ade				Mary	7	Lucil1	e	Roge	ers	
Maryland	shou ind M imar umat	-	19a. Informant's Name/Relationship	(Type. Print)		19b. Maili	ng Address (S	Street a	and Numb	er or Rural	Route Number	; City or	Town, Sta	te, Zip	Code)
	1 and 2 Health a tem 27 is		Judy W. Winblade	/Spouse						1., N	ewburg,	MD	20664	<b>'</b>	
Baltimore,		1	20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 [	Romoval from Sta	20b. Place cem	e of Dispo etery, cre	sition (Name matory or oth	of er plac	e)				ation - City		
Ĕ	permit. Pages Department of I Important: If Ite any injury or of		4 Donation 5 Other (Spec		Brins	sfiel	.d-Echo	ols	Cr.	1/12	/2008	Cha:	rlott	e Ha	a11, MD
3alt	Depart Import any in		21. Signature of Funeral Service Lice	ensee O	_	2: F	2. Name and Brinsfi	Addres	s of Facili l–Ech	ols F	uneral	Home	e. P.	Α.	
	@ OI		23a. Part1. Enter the disease, or cor	luse	M00817	] 3	0195 1	thre	e No	tch R	d. Cha	rlo	tte H	a11.	MD 20622
		4 7	shock, or heart failure. List only	one cause on eacr	n line.						теѕрлаюту ап	est,			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Thrombo	otic cere	ebrai	VASCUL	LAR	6110	ent				_	1 week
	Examiner		•		as a consequen		diso	00	,						2 years
		ē	Sequentially list conditions, if any, leading to immediate	b. Due o (or	as a consequen	ce of):	Conoc	usc							
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. Conges	tive hec	art f	allure								1 day
o,	cate be executed physician and the burial-transit	E	resulting in death) Last	Due to (or	as a consequen	ce of):									
8760,	ate be hysici the bu	dical	•	d											
9	ertific ling p	Mec	IF FEMALE:	23c. If yes, outcor	mo of programm								0/ 0 .	:	
Вох	leath certific attending p I for use as	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	n 2 ∏ Fetal de tat time of deat	eath 3	Ectopic pred					2	3d. Date of Month		ry Day Year
	the de	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknowr		II J	Tottlei (spec	<i>□11y)</i>							
, P.O.	w requires that the d been signed by the should be detached		Part II. Other significant conditions	contributing to deat	h but not resultir	ng in the u	nderlying cau	ıse give	en in Part I		23e. Did to	bacco u	se contribu	ite to th	e cause of death?
rds	quires n sign ald be	g D	diabetes								1 □ Y	es 2	No 3[	Proba	ably 4 □Unknown
S	The law requires that the death certifi ate has been signed by the attending I age 2 should be detached for use as	Completed by									24a. Was a		24b. Wei	re autop	osy findings available
Re	The la te has age 2	mo		• • •	-						autops perfor		dea	th?	npletion of cause of 2 ☐ No
ta	ician: The lav certificate has rector, page 2	Be C	25. Was case referred to medical					Olid	26. Place	e of Death	(Check only or				
r <	Physician: this certificral director,	To E	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inp	atient 2 ☐ ER	/Outpatie	nt 3□ DOA	Oth	er: 4□ Ni	ursing Hon	ne 5 Resid	ence 6	□Other (	Specify	)
0 0	ng Ph fter th ineral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of I (Month,	Injury 28 <i>Day Year)</i>	Bb. Time o Injury		c. Injur Worl			8d. Describe h	ow injury	occurred		
Sio	tendi eath. tor: A	catio	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	20			М		Yes 2□						
Division or Vital Records,	or At Iter d Direct in by	Certification:	4 Homicide determined	28e. Place of	injury - At home , etc. <i>(Specify)</i>	e, tarm, st	reet, factory,	office		2	8t. Location (S City or Tow			or Hura	l Route Number,
	pital ours a eral [		29a. Certifier 1 Certifying F	hysician: To the be	est of my knowle	edge, dea	h occurred at	t the tir	ne. date a	nd place, a	and due to the o	ause(s)	and mann	er as st	ated.
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical		iminer: On the basi and manner	s of examination										
	To the	Me	29b. Signature and title of certifier						e number				e signed (/		
			> Colude.	MD.			1	)00.	2854	14		Janu	ary 11	, 20	)OS
-	20 1		38 Name and address of person who	completed cause of	of death (Item 23	Ba) (Type	Print)	10:	10	044	ا ماليط	4.1	2011	'n	
1	2010		39 Name and address of person who Wileen D. Jude MD	23511 H	Olly WOOD 3	2 Till	Mill	101	Lec	riura	town, v	ria	WOO(		

State

Registrar

31. Date filed\_(Month, Day, Year)
JAN 1 4 2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ¹¹0, 2ď68 **Physician** Carlton Wedding William January 10:20A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 6881 Hungerford Road <u>Bryans Road</u> <u>Charles</u> 8. Date of Birth Month, Day, Year May 21, 1922 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Washington DC 85 Director 218-12-9126 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Charles Bryans Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3190 Warehouse Landing Road 20616 USA Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify White Specify: þ 3 \ Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foreman/Transportation Federal Govt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Guy C. Wedding 2 Gertrude A. King 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Guy Wedding, Jr. / Brother 7885 Port Tobacco Road, Port Tobacco, MD 20c. Location - City or Town. State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remoyal from State 4 ☐ Donation 5 ☐ Other (Specially Ombment Trinity Memorial Gard.1/14/08 Waldorf, Maryland <sub>2</sub>M00945 21. Signature of Funeral Service Licensee 22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** yan /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the marking Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2□ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 2**X** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 iving Hospital: 1 ☐ Yes 2 X No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 XNatural 5 Pending investigation

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: funeral director. After death. after death within 24 hours a

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

Medical

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

30. Name and address of person who g

6 Could not be determined

COYARD Rd 8926 7720 ARVE-31. Date filed (Mo Registrar's Signature State Registrar

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

ath (Item 23a) (Type, Print)

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

08-00218 John C. Winner Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Ce	rtificate	e of De	ath		, <u>g</u>	Rea	. No.	0 0222
Physicia		Decedent's Name (First, Middle,Last)						2. Date Mont	of Death	Day Year	3. Time of Death
ledical Exami	ner	John Carlton Winner						Jant	Jary 7,	2008	2028 hrs
		4a. Facility Name (if not institution, give street an University Hospital	d number)			y, Town, or Lo timore	ocation of	f Death		4c. County of Death	1
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthda	ay) If U	nder 1 Year	If Under	24Hrs. 8. Da	te of Birth	(MM/DD/YYYY) 9. Bir	thplace (State or
Director		220-66-5133 1XX <sub>M</sub> 2	F 52		Yrs. Mo	nths Days	Hours	Min. 07/	10/1	.955 Foreig	n <sup>untry)</sup> Maryland
		Usual Residence of Decedent									
w any		10a. State 10b. County		, Town or	Location						10d. Inside City Limits
Aaryland 28a-f show Latonce	ō	Maryland Prince George	s.s Ro	wie							1 XXYes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health is and Mental Hygiens the "hastural", or items 23a or 28a-f she important: If tiem 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Director	10e. Street and Number 2703 Belair Drive			10f.	Zip Code 20715			100	g. Citizen of What Coul	ntry?
h with	uneral		Decedent Ever in to d Forces?	J.S. 1				in? ( Specify Ye Puerto Rican, e		14. Race - Amer White, etc.	ican Indian, Black,
r deat	Fun	1Y	es XX No			2XX No		,	,	7.7	hite
rs afte ural",	þ	3 Widowed 4 Divorced If Yes, Give or Dates:  15. Decedent's Education (Specify only highest						ind of work dor	ne l	Specify: W  16b. Kind of Business/	
hin 72 hou e. than "nat	eted		je (1-4 or 5+)			working life. [				Amerinet	· ·
5-0036 led within 7. Hygiene. I other than the Medical	Complete	-12-		Comp	uter	Tech				-	
5-003 led within Hygiene. lother th	ပိ	17. Father's Name (First, Middle, Last)					3.Mother's	s Name (First, I	viiddle, M	aiden Surname)	
121 d be fi ental arked	Be	Richard Harold Winner		T						s Morris	
Baltimore, MD 21215-003 permit. Pages I and 2 Abould be filed within Department of Health and Mental Hygiene. Important: If liene 27 is marked other it injury or other traumatic event, the Med	٩	19a. Informant's Name/Relationship (Type, Print Susannah D. Winner/wit			-	,				per, City or Town, State ${ m ryland} \ \ 207$	
mand 2 sho ealth and lem 27 is traumati		20a. Method of Disposition		Place of D	Disposition (	Name of ceme		Date	, Ma	20c. Location - City or	
Baltimore, permit. Pages 1 at Department of Her Important: If ite		1 XXBurial 2 Cremation 3 Remov	al from State	,	or other pla	,		01/10/0		D	. 1 1
ltimen ritmen y or c		4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee	110	rt Li	ncoln	and Address of				Brentwood Evans Fun	
Ba perm Depa Imp		Jet f. Kjuil								e, Marylan	
Physician		23a. Part I. Enter the disease, or complications the	at caused the deat	h. Do not e							Approximate Interval Between Onset and
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple	Injuries								Death
lanniei			as a consequence	of):							
	Ŀ	Sequentially list conditions, if any, leading to immediate b. Due to (or	as a consequence	of):							
	Ĕ	cause. Enter Underlying Cause									
ed	Examiner	events resulting in deathy Last	as a consequence	of):							
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760, Teate be ex physician the burial	Medical	IF FEMALE: 23c. If y	res, outcome of pre	gnancy						23d. Date of deliver	<u> </u>
k 687 h certifica ending p	an/I	23b. Was decedent pregnant in the past 12 months?	ve birth	2	Fetal dea	ath 3	Ectopic	pregnancy		Month	Day Year
Box 68's death certificate attending	sician/	4 No. 2 No. 2 University 1	regnant at time of d nknown	leath 5	Other (\$	Specify)					
C the bear	Phy	Part II. Other significant conditions contributi		resulting in	n the underly	ing cause giv	ven in Pa	rt I. 23	e. Did tob	 pacco use contribute to	the cause of death?
ires that is signed b	by							1	Yes	2 No 3 Pro	bably 4 Unknown
Records, The law requiring a second to be se	Completed							24	a. Was a		utopsy findings available completion of cause of
e law e has e has	ш								autops perform Yes 2	ned? death?	·
tal Recian: The	ပ္ပိ	25. Was case referred to medical				26.Place	of Death (	Check only on			65 2 140
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Division tal or Attendi rs after death.	Certification:	3 Suicide 6 Could not be 28e.	Place of Injury - At			tory, office bu	ilding, etc				ural Route Number, City
Divisior Bospital or Attenc 24 hours after death Funeral Director:	Ser	on Ontifer —	cify) Major Roa							ate) ir Priest Bridge Road	
he Hot in 24 h he Fur pletely	edical	29a. Certifier 1 Certifying Physician: To the (Check only one) 2 Medical Examiner: On the ba	-								
To the within 2 To the complet	Med	and manr 29b. Signalure and title of certifier	ner stated.			29c. License	number			29d. Date signed (Mo	onth, Day, Year)
		(Cal la 11)				O.C.M	1.E.			January 9, 2008	i e
		30. Name and address of person who completed	cause of death (Ite	m 23a)							
44			lical Examiner		enn Stre	et, Baltim	ore, MI	D 21201			
St Regis	ate	31. Date filed (Month, Day, Year) JAN 1 1 2008 3	2. Refistrar's Signa	ture	ben	4.					
DHMH 17 Rev 1/2		DAIL I T FOOD		ORIG	SINAL		_			···	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** PAUL Robert SANUARY 18:22 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SOHNS HOSPITAL BRUTIMORE HOPKINS C17 If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 M 2 F 59 577-62-6699 Director 6/1/1948 Washington, D.C. Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Maryland Calvert Dunkirk Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Regent Court 20654 2191 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes X No Saltimore, Maryland 21215-0036 Specify: White Completed by 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical Painting Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Menta Margaret Arey ဥ Jimmy Yee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traumonce. 16301 Manning Rd. W. Accokeek, MD Kendra Hasselbrick-Daughter 20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State

20c. Location - City o 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Arehart-Echols Funeral Home, La Plata, Md. P.O. Box 567 M-00174 20646 Approximate Interval Between Onset and Death 23a. Part1. Friter the disease, or complicatio. If a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, I heart failure. List only one in use in each line. Immediate Cause (Final ENDOCARDITIS MONTH **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): KENAL FAILURE 11 MONTHS Examiner END - STAGE Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): attending physician The law requires that the death certificate be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No Division or Vital or Attending Physician: after death. Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and a rress of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MAKYLAND 2178 STKEET BATH WOLFE SONATHAN NORTH 600 32. Registrar's Signature Day, Year) 1 4 2008 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001

			For State		State of Ma	aryland /					ntal Hy	giene			
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-	Physici	am			,	77.0					Month	Day	Year 2008	6.	10P M
	/Medio	181			SON ADEBZ ve street and number)	4 Y O		4b. City, Town,	or Location of		32111	7	County of Death		105
			SOUTHE	RN MARY	LAND HOSE	PITAL		CLIN	ITON If Under				RINCE C	EORG	GES
	Funeral		5. Social Security N	lumber 6. S	Sex 7. Age	e (In yrs. last	<i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	B. Date of Birt (Month, Da	h y, Year)	Cot	intry)	ate or Foreign
T ess	Director		247-29- Usual Residence of	-7888	4	5	115.				10/7/1	1962	2 SOUT	'H C	AROLINA
	laryland show		10a. State	10b. County		10c. City, To	own or Lo	cation							de City Limits
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21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	b	11. Marital Status 1	ied 2[XMarried 4 □ Divorced	12. Was Decedent of Armed Forces? 1 □ Yes 2 ▼ If Yes, Give Year or Dates:		'	Was Decedent of f Yes, specify Cu 1 □ Yes 🏋 No	ban, Mexica	n, Puerto Ri	ify Yes or No ican, etc.)		14. Race - Amer Black, White Specify: BI	, etc.	n,
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Maryland	2 should be and Mental is marked cramatic ew	-	19a. Informant's Na					ng Address (Stree							
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Ba	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai		Ken	40 dl	Stivoul		6	500 ALI	ENTO	WN RI	O. CAI	MP S		5, MI	D 20748
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	Physician /Medical		Immediate Cause disease or condition resulting in death)	in in	a. Due to (or as	10X1C	oo of):	enc	eph	alo	path	_			
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O. Box 6	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending placemplately filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	by Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknow	months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	ath 3	⊒Ectopic pregnan □ Other (specify)	су				23d. Date of deli Month	ivery Day	Year
P.O.	that the d ed by the detached	Ph/	Part II. Other signi	ficant conditions	contributing to death b	ut not resultin	g in the u	nderlying cause g	iven in Part	ſ.	23e. Did t	obacco (	use contribute to	the cause	e of death?
rds	quires n signe	d b		_ K	Mpm						1 🗆	Yes 2	<b>V</b> 1 o 3 □ Pr	obably	4 ∐Unknown
Vital Records,	The law requii ate has been s page 2 should	Completed									24a. Was auto perfo 1□ Yes		prior to death?	completion	lings available n of cause of
Vita	ysician: The is certificate director, pag	Be	25. Was case reference examiner?		Hospital:				ther:		(Check only o				
	Phys rthis ral dir	인: 1	1 Yes 2		28a. Date of Inju		Outpatier b. Time o	# STI DOW	4 ⊔ N		e 5 ☐ Resi 8d. Describe		6 ☐Other (Sperry occurred	cify)	
Division or	nding Ph th.: After the funeral	tion	1 ☐ Natural 2 ☐ Accident	5 ☐ Pending investigation	(Month, Da	y Year)	Injury	W	ork? □Yes 2□						
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	To t To t	Σ	29b. Signature and	I title of certifier				29c. Lice	nse number	2.6		29d. Da	ate signed (Mont	h, Day, Ye	ar)
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	3		30. Name and add		completed cause of d	leath (Item 23	sa) (Type,	Print)	1001	^	1000 2	200	10010	) 0, -	725
	Sta	ate	31. Date filed (Mor	nth, Day, Year)	32 Registr	ar's Signatur	220	25/6/	, rea		(/  ¥   */	VVI	11-11	/	
	Regist	rar		JAN 3 0	2008	Sand Sand	Sta Sta	6							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 2876 2-6-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 27, 2008 Cecilia G. Alessi Ø645AM CECELIA G. ALESSI 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Towson Baltimore Saint Joseph Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days 1 □ M 2 X F 219-05-5796 94 4/24/1913 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No MD BALTIMORE **ESSEX** 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 1000 FRANKLIN AVENUE APT. 419 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7TH GRADE SEAMTRESS FACTORY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ROBERT ADAMS ELIZABETH UNAVAILABLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1768 WESTON AVENUE BALTIMORE, MD 21234 e of Disposition (Name of Date 20c. Location - City or Town, State DOROTHY BROWNING/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 1/31/2007 CATONSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 110 Low 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GASTROINTESTINAL HEMORRHAGE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last July to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an RENAL INSUFFICIENCY autopsy DEMENTIA 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r 28a-f show notified at

Funeral Director

Be Completed by

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

1 and 2 should be filed within 72 hours after death with Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 1

item 27 other t

Pages 1 permit. Pages Department of I Important: If its any Injury or o

sician and burial-transit requires that the death certificate be executed Po page 2 director, this

Physician/Medical

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Be Completed

Certification: To

Medical

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

To the Hosp within 24 hor To the Fune completely fi

n 24 hours after death.
he Funeral Director: A
pletely filled in by the ft

State

Registrar

6 ☐ Could not be

determined

29c, License number D31826

11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

7601 OSLER DRIVE TOWSON. MARYLAND RICHARD LINTHICUM. M. D. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

08-00727 Ernest L. Atkinso		Brd Sind Sind For State	<b>pe or Print ir</b> tate of Maryla	ind / Depar	tment o	Ink. Ensu of Health a of Death	re All Co nd Mental	l Hygiene	_	08 0223
Physicia Medical Exami	an/	1. Decedent's Name (First, Midd Ernest L. Atkin	son, 3rd					2. Date of Dea Month January 2	th Day Year 6, 2008	3. Time of Death 1546 hrs
		4a. Facility Name (if not institution 8603 Oakdale Street	-	mber)		4b. City, Town, Fort Wash		eath	4c. County of Dea Prince Georg	
Funeral Director		5. Social Security Number 113-58-1656	6. Sex	7. Age (In yrs. las		If Under 1 Yours.		4Hrs. 8. Date of Bir Min. May 14	th(MM/DD/YYYY) 9. E Fore	
nd thow any	ڀ	Usual Residence of Decedent  10a. State MD  10b. County		10c. City, T	own or Loc	ation Fort W	ashington	ı		10d. Inside City Limits 1 X Yes 2 No
) (C) I the Marylar 3a or 28a-f otified at on	Director	10e. Street and Number 8603 Oakdale St	reet			10f. Zip Code	20744	1	0g. Citizen of What Co USA	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Ti firem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral		12. Was Dec Armed Fo 1 Yes vorced If Yes, Give Yea	2XX No	If		an, Mexican, Pi	(Specify Yes or No uerto Rican, etc.)	14. Race - Ame White, etc. African Specify:	American
72 hours aft n "natural" al Examine	ompleted by	15. Decedent's Education (Spe Elementary/Secondary (0-12	ecify only highest grad  College (1	de completed) -4 or 5+)	16a. Deced	ent's Usual Occur most of working I	pation (Give kin		16b. Kind of Busines	
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215- be filed ntal Hyg ent, the	Be C		. Atkinson,	Jr.				Sarah	Brayboy	
21, should b nd Mer is mar	7	19a. Informant's Name/Relation Ernest L. Atkin							mber, City or Town, Sta ca, New York	
e, MD and 2 sho lealth and tem 27 is	. 22	20a. Method of Disposition		20b. Pl	ace of Disp	osition (Name of		Date	20c. Location - City	
nore		1 X Burial 2 Crematic	-	UIII State		other place) Cemetery	o	2/02/2008	Chester, So	uth Carolina
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite		21. Signature of Funeral Service			ŀ	. Name and Addr		5	eral Home, P.	Α.
Physician	1	23a. Part I. Enter the disease,	r complications that c	aused the death. I					e, MD 21217 rest, shock, or heart	Approximate Interval
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Division of Vital Records, P.O. Box 68760, within 24 bours after death certificate be executed within 24 bours after death. To the Funeral Direct After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 U	the 1 Live b	nant at time of dea	2 🗌	Fetal death Other (Specify)	3 Ectopic p	regnancy	23d. Date of deliv Month	ery Day Year
P.O. B es that the digned by the	by	Part II. Other significant cond			sulting in th	e underlying caus	se given in Part		tobacco use contribute	to the cause of death?
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al Rein: The	Se Cc	25. Was case referred to medic examiner?				26.Pl	ace of Death (C			
f Vita Physici or this c	To B	1 Yes 2 No 27. Manner of Death	Hospital: 1	<u> </u>	ER/Outpation 28b. Time of		Other 1	Nursing Home 5	Residence 6 🗸 Ot	her: Scene
on on on on other transfer of the other or other transfer or other	tion:	1 X Natural 5 Pe	(Monti nding	n, Day,Year)	200. Time (	· · ·   _	Yes 2 N		, , , , , , , , , , , , , , , , , , ,	
Division of Vital F  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Co	estigation 28e. Place	ce of Injury - At ho	me, farm, st	reet, factory, office	ce building, etc.	28f. Location or Town,		Rural Route Number, City
fo the Hosp vithin 24 ho fo the Fund completely f	Medical C	one) 2 ✓ Medical Ex	aminer: On the basis and manner s	of examination an	e, death oc	gation, in my opir	nion, death occu	e, and due to the cau	use(s) and manner as see and place, and due to	the cause(s)
- > - >	ž	29b. Signature and title of certif	fier VC D D				ense number C.M.E.		January 27, 20	
		30. Name and address of person						ND 0122		
		Margarita Korell MD.		dical Examine		Penn Street	, Baltimore,	MD 21201		
	tate trar			egistiai s Sigilatui	e Alama					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend 7 per B.C. g876 2/21 @8tiffice of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician /Medical 4b. City, Town, or Location of Death 4c. County of Deat 4a. Facility Name (If not institution, give street and number) Examiner Battimore 2568 Baltimo If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

2 19 5. Social Security Number 220 - 79 - 145 Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 DF 11/8/07 Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10h. County 1 Tes 2 No Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number o e Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. "natural", or items 23a edical Examiner must b by Funeral Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 III If Yes, Give Year or Dates: 2 1 Never Married 2 Married 1□Yes 2⊡No Baltimore, Maryland 21215-0036 Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than any Injury or other traumatic event. He Mea Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Baldwir ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State provine 4 Donation 5 Other (Specify) 21. Signature of Fureral Service License Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Da Physician 1 visom disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical as the attending IF FEMALE: use yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 2 Fetal death for Month Year in the past 12 months? Day 5 ☐ Other (specify) ☐Yes 2☐No the detached 9□Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ wolog 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed death? 1 ☐ Yes 2 ☐ No 2 No certificate 1□ Yes Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred completely filled in by the funeral 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30, Name and add en of person who completed cause of death (Item 23a) (Type, Print) PENN ST, Baltimore, MD

Registrar

31. Date filled (Month, Day, Year) State 0

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2 Date of Death 3. Time of Death Month **Physician** -00 A M 2008 nuary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MANOR AVE ATO 13360 WILKENS

7. Age (In yrs. last birthday)

Yrs. 21229 BALTINORE BALTIMORE COENESIS If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Month, Day ocial Security Number 9. Birthplace (State or Foreign **Funeral** 11 M 2□ F Days Hours Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 Yes 2 No Director ND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ould be filed within 72 hours after death with Mental Hygiene. USA or items 23a Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Black Baltimore, Maryland 21215-0036 þ Specify: 3 ☐ Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) is marked other than condary (0-12) Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Pages 1 and 2 should nent of Health and Mer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature uneral Service Licen 23a. Pour Enier ne isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, The art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate area (Final disease or o indition resulting in death) days PNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner END STAGE monetry DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed COPD and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 Probably 4 Wiknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the f 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 29a. Certifier : Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier up Le MD DO053150

State Registrar 9650 SANTIAGO RD

21045

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAKUNMALA

3 0

31. Date filed (Month, Day, Year)

QUPTA

324 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Division or Vital Records, P.O. Box 68760

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

30 Name and address of person who

31. Date filed (Month, Day,

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

0010

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 27 20°68 **Physician** Jan 9: 45 avm George Bartlett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Towson Gilchrist Hospice 8. Date of Birth (Month, Day, Year) 4/6/24 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 ☐ F 83 061-44-1208 Director West Ind. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show be notified at Director N/A 1 ☐ Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a 1049 St. Marlyn Ave "natural", or items 23a 21221 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 27 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: West Indian Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction the Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be I and 2 should be fi fealth and Mental F is marked Charles Bartlett Helen Bartlett P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 1313 Nautica Cicle, Essex, MD 21221 Danielle Lamothe/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) \_\_\_ 2/2/08 Baltimore, MD Trinity Cem 22. Name and Address of Facility Hari P. Close F.Svs, PA 21. Signature of Fu I Service Lin nsee 5126 Belair Rd, MD 21206 Balt., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition FROSTATE CANCER, METASTATIC **Physician** disease or condition resulting in death) YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be exect Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 █ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2**24**No 1∐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Her (Specify) HUSICE 1 | Yes 2 | 2000 2 ER/Outpatient 3 DOA Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Puneral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi

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Registrar

DOBERMAN, MA DANIEUE 31. Date filed (Month, Day, Year) State

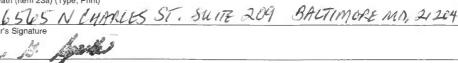
(Check only one)

29b. Signature and title of certific

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 0



January 27,2008 at 945A

064395

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of M	aryland /		nent of He icate of D		vientai Hy		7 11 11	8 (	02239
73		75	Decedent's Name (First, Midd	e, Last)			10010 07 2	- Catri	2. Date of D				. Time of Death
3	Physici /Medi		Donald		Bride	ensti	ne		Janva		ay Ye 22 200		77:30 M
	Examir		4a. Facility Name (If not institution	n, give street and number,				Location of Death			c. County of		. ,,,
	n is to the compact administrative and articles		JOHNS HOPK  5. Social Security Number	ns Hospi	TAL	E	saltimo	DRE CIT					
-/4	Funeral Director		210–12–1161	6. Sex 1 <b>X</b> M 2 □ F	ge (In yrs. last b	Yrs. If	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of B 04/12	irth 192 192	9. P	Birthplace Country)	(State or Foreign
	land w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Location	on					10d.	Inside City Limits
	Mary f sho	Ď	PA Hun	tingdon	W	lood To	wnship						1 □ Yes 2 X No
	r 28a	irec	10e. Street and Number			1	Of. Zip Code			10g. C	itizen of What	Country?	
	h witl 23a o st be	a D	Box 21				16674				Unite	ed St	ates
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2⊠ Mar 3 □ Widowed 4 □ Divorced	If Yes, Give	?			spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	0-	14. Race - A Black, V Specify:	merican li /hite, etc. Whit	
5-0	72 hc natu	eted	15. Deceder	t's Education st grade completed)	168	a. Decedent	s Usual Occupa	tion	kina	16b.	Kind of Busine	ss/Indust	ry
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Maryland	ould be fi Mental H arked ot	Be	17. Father's Name (First, Middle,					18. Mother's Nan		•	n Surname)		
Ž	should and Men marke	으	Harvey Briden  19a. Informant's Name/Relations		10	Dh. Mailing A	dross (Street a	Gladys			Or Town Cto	7:- 0-	-(-)
Ma	und 2 sho alth and 27 Is ma er trauma		Lora Bridensti					tsdale,			or rown, Stat	e, zip coi	ae)
ē,	s 1 and 2 f Health tem 27 I		20a. Method of Disposition				n (Name of ry or other place		Date		Location - City	or Town,	State
Baltimore,	permit. Pages Department of I Important: If ite any injury or o		1 N Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5 21. Signature of Funeral Service	pecify)	Ave	Marie	Cemeter	y 01/26			ley, P		
Ba	permit. Departr Importa any inj		Tellet		01113	P.O.	Box 21	s of Facility Cu 4, Broad	d Top C	ity,			. Home
			23a. Part1. Enter the disease, o shock, or heart failure. List	complications that cause only one cause on each li	d the death. Do ine.	not enter th	e <i>m</i> ode of dying	, such as cardiad	or respiratory	arrest,		Inte	proximate erval Between
¥.	Physician		Immediate Cause (Final disease or condition	-a. Preum	onia	and c	eriork	ortal ce	11071.415	-			set and Death 18 month
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):							
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68760,4	al-tra	edical Examiner	that initiated events resulting in death) Last	C Due to (or as	a consequence	e of):						+	
760	e be (sicial	cal		C <sub>d</sub>									
89	tificat g phy as the												
P.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal deat		opic pregnancy ner (specify)				23d. Date of Month	delivery Day	y Year
	that ned by deta		Part II. Other significant conditi	ons contributing to death b	out not resulting	in the under	ying cause giver	n in Part I.	23e. Did	tobacco	use contribut	e to the ca	ause of death?
rds	quires n signe ald be	d by							1 🗆	Yes 2	2 <b>⊠</b> No 3□	Probably	4 □Unknown
or Vital Records,	<b>nysician:</b> The law require his certificate has been sig I director, page 2 should b	Completed								s an opsy formed?	24b. Were prior death	to comple	findings available tion of cause of
ā			25. Was case referred to medica					00 81 - 78	1□ Yes	2 <b>/Z</b> I N	lo 1 🗆 Y	es 2□	] No
Š	Physician: this certific	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 D FR/O	outpatient 3	Other	26. Place of Dea	tn <i>(Check only</i> ome 5□ Res		6 DOther /6	In = 0 (6 s)	-
ō	g Phys er this eral dii	n: To	27. Manner of Death	28a. Date of Inju	ıry 28b.	. Time of	28c. Injury Work?		28d. Describe			pecity)	
Division	ath. r: Aft	Certification:	1 ☑ Natural 5 ☐ Pendir 2 ☐ Accident investi	g (Month, Da jation	y rear)	Injury I		es 2 No					
<u>&lt;</u>	r Atte er de recto by th	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inod   Zoe. Place of In	ury - At home, f	farm, street,	factory, office		28f. Location	(Street a	and Number or	Rural Ro	ute Number,
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)  1 Certifyir 2 Medical	g Physician: To the best Examiner: On the basis o and manner st	of examination a	ge, death occ and/or investi	curred at the time gation, in my opi	e, date and place inion, death occu	, and due to the rred at the time	e cause( , date ar	s) and manner nd place, and	as stated	d. cause(s)
	To th withii To th comp	Ĭ	29b. Signature and title of certifie				29c. License	number		29d. Da	ate signed (M	onth, Day,	Year)
	4		taska M	oreta MEDI	CAL DO	XTOR	RES	5-00	5	Jan	vary	22	2008
	CXI		30. Name and address of person	who completed cause of o	leath (Item 23a)	(Type Print	)						
	10		Fasika Wore + a  31 Date filed (Month Day Year)	, Johns Ho	pkins +	tospit	al 600	North Wo	lfe Street	of Bo	altimor	e Mi	D 21287
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	negisti	ш.	JAN	The State of the said	and a state	Service Control							

DHMH 17 Rev 1/2001

U8-00328 Edwin Joseph Be	am	Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental H		ble.	00010
Edwin ooseph be		1- For State Certificate of Death		201	08 02240
Physicia		1. Decedent's Name (First, Middle,Last)	Reg. 2. Date of Death		3. Time of Death
Medical Examin		Edwin Toseth Beam	Month D January 12,	2008 Year	0712 hrs
le de la constant de la constant de la constant de la constant de la constant de la constant de la constant de		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	)	4c. County of Dea	
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Director	ı	2/8-98-94/3 1 M 2 F 35 Yrs. World Style 10013	Huly 25	11972	Country) MD
any		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location	·		10d. Inside City Limits
	اءِ	M) Baltimore Dundalk			1 Yes 2 No
farylar 28a-f at on	Director	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Co	ountry?
bours after death with the Maryland "natural", or items 23a or 28a-f show Examiner must be notified at once.		8136 Bletzer Road 21222		U.S. A	-
ms 2.	Funeral	11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? ( S  14. Marital Status  15. Was Decedent of Hispanic Origin? ( S  16. Hispanic Origin? ( S  17. Marital Status		14. Race - Am White, etc.	erican Indian, Black,
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2 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		4	
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5-0036 led within 7 Hygiene, other than			e (First, Middle, Ma	iden Surname)	
21215-003 Juld be filed withi Mental Hygiene marked other it cevent, the Mental	a	Lindy Raymond Dolo		Seam	
Imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Take 1 is marked other than "natural", or items 23a or 28a-f shoot other traumatic event, the Medical Examiner must be notified at once	ဥ	19a. Informant's Name/Relationship (Týpe, Print )  19b. Mailing Address (Street and Number or	Rural Route Number	er, City or Town, Sta	ate, Zip Code)
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is in injury or other traumatic.		Do / o res Leam US walf - Mo the Marett Ct, Lot Al 20a. Method of Disposition (Name of cemetery,	Date 2	20c. Location - City	or Town, State
Baltimore, permit. Pages 1 a Department of the Important: If it		1 Burial 2XX Cremation 3 Removal from State Bayyon worth Crematory	-21-08	Baltimore	e,MD
it. Partmen		The state of the s		MICHELLA	TCR, MAD
Ba Departi		Home DA 2134	radley-	- ASKTON	FUNERAL Rd, 21222
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyirlg, such as cardiac failure. List only one cause on each line.	or respiratory arres	t, shock, or honrt	proximate Interval Between Onset and
/Medical. Examiner		Immediate Cause (Final disease a. Heroin intoxication and cocaine use			Death
Zammer		or condition resulting in death)  Due to (or as a consequence of):			
	e	Sequentially list conditions, if any, leading to immediate			1.5
17.7	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated			
list A fed	Exa	events resulting in death) Last  Due to (or as a consequence of):  d.			·
	ical	X AMENDED X AMENDED 20a-c Per FH C875 1/30/08 Jh #23a 27 28a-f per FH c875 1/31/08 T			
60, ate be shysici e buri	cian/Med	#23a_27_28a=fperMF_g8751/31/08_1  IF FEMALE: 23c. If yes, outcome of pregnancy	7	23d. Date of deliv	very
Box 68760, e death certificate be the attending physic ed for use as the bur	an/I	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregn	ancy	Month	Day Year
lox eath c	S.	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown			
	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
P.O.	d b		1 Yes	2 No 3 F	Probably 4 🗹 Unknown
of Vital Records, ng Physician: The law requin ther this certificate has been s' neral director, page 2 should be	Completed		24a. Was an autopsy		autopsy findings available to completion of cause of
eco he law ite has	щ		perform 1 ✓ Yes 2	ned? death	?
al R nn: Ti srtifica tor, pa	ou l	25. Was case referred to medical 26.Place of Death (Check			
Vita hysici this ca	0 B	examiner? 1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other Nursi	ing Home 5 R	Residence 6 🗸 Ot	her: Scene
n of ing Pl After funera	T:T	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	ow injury occurred	
Division tal or Attendirs after death.	Certification:	2 Accident Investigation Fnd 1/12/2008 Fnd 7:08 am	unk	- A A No h	Dural Dauta Number City
Divis	Ě	3 Suicide 6 X Could not be determined (Specify) Sound at home	or Town, Sta	ate)	Rural Route Number, City
Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page		29a, Certifier		(s) and manner as s	
the II hin 24 the F	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	at the time, date ar	nd place, and due to	the cause(s)
To vit	Me	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (	Month, Day, Year)
		Donna mi incenti, M.D. O.C.M.E.		January 12, 20	800
		30. Name and address of person who completed cause of death (Item 23a)			
10		Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, N	ИD 21201		
Sta		31. Date filed (Month, Day, Year)  JAN 3 0 2008			
Registr	ŒП	JAN O U LOVO ARRENOS POR PROPERTIES	<del></del>		

DHMH 17 Rev 1/2001

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amend item State of Mary 1887 6 Department of Health and Mental Hygiene

		_	For State Registrar	State of Maryleric		rtificate of De	ath	Reg	. No.2 0 0 8	02241
	Physicia	_	Decedent's Name (First, Middle, Lass     HAROLD	t) H		BROZER		Date of Death Month JANUARY	Day Year 200	3. Time of Death  9:40A M
12 P	/Medic Examin	42.3	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Loc	cation of Death		4c. County of Dea	th
	Funeral	ш	RUXTON OF PIKESV  5. Social Security Number   6. S	ex 7. Age (In yrs. In				Date of Birth	BALTIMOR	thplace (State or Foreign
** **	Director		215-18-9082	XM 2□F 89	Yrs.	Months Days H	lours Min.	Date of Birth Worth, Day, Y	918	MD MD
	yland Iow		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	e Man Ba-f sh ptified	Director	MD BALTIM	ORE BAL	TIMOR					1 ☐ Yes 2 ☐ No
	a or 2		10e. Street and Number 7 SUDBROOK LAN	ΙE		10f. Zip Code 212	08	100	g. Citizen of What C USA	ountry ?
	r death ems 2:	Funeral	11. Marital Status	12. Was Decedent Ever in U.S	S. 13.		nic Origin? (Specify Mexican, Puerto Rica	Yes or No- an, etc.)	14. Race - Ame Black, Whi	
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 (X) Yes 2 □ No WW If Yes, Give Year or Dates: ARMY	,11	1 □ Yes 2 🕱 No S	pecify:		Specify:	WHITE
Maryland 21215-0036	72 hou "natura	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece (Give	dent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of working	16	6b. Kind of Business	/Industry
2121	within jiene. r than the Me	фшо	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	SALESPERSO		S	AUDER COR	PORATION
nd	be filed Ital Hyg Id othe event,	Be	17. Father's Name (First, Middle, Last)		DDO	1	. Mother's Name (Fi	irst, Middle, Ma	aiden Surname)	LAZINS
	should nd Mer marke imatic	2	SAMUEL  19a, Informant's Name/Relationship (*)	Type. Print)	BRO 19b. Maili	ng Address (Street and	Number or Rural Re	oute Number, (	City or Town, State,	
, Ma	and 2 sealth an n 27 is ler trau		ROSALIE RAIM /		6317	PARK HEIGH	ITS AVENUE	APT.	#307, BA	LTIMORE, MD
nore	Pages 1 nent of H int: If Iter iry or oth		20a. Method of Disposition  1	Removal from State 20b. P	lace of Dispo emetery cre	osition (Name of majory or other place) DN - CHIZUK CONG.	Date		Oc. Location - City o	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mendial Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer		2	2. Name and Address of	f Facility SOL	LEVINS	BALTIMORE ON & BROS	., INC.
m T	8 3 E 8 8		23a. Part1. Enter the disease, or com	olientions that caused the death		8900 REISTE				
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	^		l'sease	ophatory arroa	,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	a Due to (or as a consequ	1 011		, 0 - 40 -	· ·		1-40 5
k		er	Sequentially list conditions, if any, leading to immediate	b Due to (or as a consequ	uence of):					
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
68760,	intificate be executed ing physician and as the burial-transit	cal E	· ·	Due to (or as a consequent	derice or).					
	rtificate ng phy e as the	Medical	IF FEMALE:				-			
.O. Box	The law requires that the death cer tte has been signed by the attendin age 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do	Ideath 3[	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	elivery Day Year
P. O.	at the d by the tached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
ds,	signed be de	by	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	ınderlying cause given ir	n Part I.	23e. Did toba		to the cause of death?  Probably 4 ☐ Unknown
Vital Records,	aw requ s been 2 shoul	Completed						24a. Was an		autopsy findings available completion of cause of
E E		Com						autopsy perform 1□ Yes 2	ed? death? XNo 1 □ Ye	
	scertifie irector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🕻 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	10	6. Place of Death (C		) nce 6 □Other (Sp	ecify)
n or	tending Physician: eath. tor: After this certific the funeral director,	on: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injury at Work?	28d		v injury occurred	
Division or	or Attending Physician: after death. Director: After this certifica in by the funeral director, i	fication	2 Accident investigation 3 Suicide 6 Could not b	28e. Place of injury - At ho	me, farm, st		2 □ No 28f.			Rural Route Number,
2	tal or / rs after al Dire	Certification:	4 _ Horniciae	building, etc. (Specify				City or Town,		
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)  1 ▲ Certifying Ph 2 ☐ Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, dea tion and/or i	th occurred at the time, nvestigation, in my opini	date and place, and ion, death occurred	d due to the car at the time, da	use(s) and manner a ite and place, and d	as stated. ue to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. License nu			d. Date signed (Mo	
	$\cap$				000) (7		37573		January	8005,25
	, 7		30. Name and address of person who	MD 25 N	lain	st. Rel	Hestour	ME	21136	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Pegistrar's Signa	ture A	part				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Mary K. Brandau 8:30 PM Town 26 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
Nov. 26,1955 Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) Days Hours 1 M 2 → F 216-66-3232 52 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3503 Crossland Ave 21213 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Lauer Katie Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. Rider Brandau-Husband 3503 Crossland Ave Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro 1/28/08 Baltimore, MD 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc 21. Signature of Funeral Service Licensee 6415 Belair Rd Baltimore, MD 21206 23a. Part1. Enter the diseas proplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail up that only one cause on each line.

Immediate Cause (Find disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death mitral regurgitation Due to (or as a consequence of): MILVER Regura, Latinen Valve Dus to (or as a consequence of). endocorrditis Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

Physician /Medical Examiner

item 27 l

permit. Pages 1
Department of H
Important: If ite
any injury or ot

**Physician** 

/Medical

Examiner

**Funeral** 

Director

a or 28a-f show the notified at

r than "natural", or items 23a the Medical Examiner must b

Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or?

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

page 2

in by the funeral director,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

autopsy performed?

1 Yes 2 X No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical examiner? Hospital: 1 ☐ Yes 2 No 1 🔀 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 5 Pending investigation 1 X Natural 2 Accident

3 Suicide 6 ☐ Could not be 4 ☐ Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29a. Certifier

AT 24389 46

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

Alcheikh MD

Alcheinh

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28c. Injury at Work?

2008 26

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

Elie 31. Date filed (Month, Day, Year)

and manner stated.

JAN 3 0 2008



The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending physician for use as the buria been signed t should be det this or Attending the Funeral 24

State Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 29, **Physician** JOHN RUSH CRUNKLETON JR JANUARY 2008 04:05M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Year Min. | March 10, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ), 1918 Mary land 215-18-9484 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Directo Maryland | Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6643 Walnutwood Circle 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? XQXYes 2 □ No WWII If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White Specify: \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Mattress Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Rush Crunkleton Sr Mary Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6643 Walnutwood Circle Baltimore, Maryland 21212 Jean Fox Crunkleton Wife 20a. Method of Disposition
1 Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 Removal from State GreenMount Crematory 1/31/08 Baltimore, Maryland Donation 5 ☐ Other (Specify) ignature of Funeral Service License 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc arkis 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, complications of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): Examiner CHORNIC OBSTRUCTIVE PULMONARY DISEASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ACUTE RENAL FAILURE 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an s certificate has b irector, page 2 s ISCHEMIC CARDIOMYOPATHY 1∐ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide n 24 hou. The Funeral P 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the Hosp within 24 hor To the Fune completely f and manner stated. 29b. Signature and title of certifier 29c. License number Pate signed (Month, Day, Year) felore, M.D. 2008 D17695 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. D. 7601 OSLER DRIVE TOWSON. MARYLAND LAH \$2. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 3 0 2008 Registrar

DHMH 17 Rev 1/2001

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edical	hysic Exan				Date of Death     Month	Dav Year	3. Time of Death 1109 hrs
			4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	January 28,	4c. County of Death	
F	unera	P	Sinai Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore	16 B (B) #	UA	
	recto		238-46-1679 12m 2 F 73	If Under 1 Year If Under 24H Months Days Hours M	in. Happy 6		thplace (State or Foreign untry) RHI (ARD (INA
	any		Usual Residence of Decedent  10a State 10b. County 10c. City, Town or Locat		VINKEY	7131 10	
pu	. ₹	_ ا	Hand land 10/4 Ball.				10d. Inside City Limits  1 Yes 2 No
Maryla	23a or 28a-f show notified at once	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Cour	itry?
vith the	s 23a o	al Di	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	21215		LISA	
de ath v	or item	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	s Decedent of Hispanic Origin?(S es, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
ırs after	dental Hygiene. narked other than "natural", or items event, the Medical Examiner must be			Yes 2 No specify:		Specify:	HMERICAN
<b>6</b> 172 hou	an ''nat	leted	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use re	tired)	6b. Kind of Business/Ir	ndustry
<b>-003</b> d within	giene. ther th	Completed by	17. Father's Name (First, Middle, Lest)	/ WORKER		Bethlehen	JEE/
<b>21215-0036</b> July be filed within 7	ental Hy arked o vent, th	Be	SAWARNE COMMANDER	Str.//	e (First, Middle, Maid	den Surname)	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland	of Health and Mental Hygiene.  If item 27 is marked other than "natural", her traumatic event, the Medical Examiner	ď	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing	111	Rural Route Numbe	er, City or Town, State,	Zip Code)
re, N	nt of Health and N it: If item 27 is n other traumatic			tion (Name of cemetery,	Date 2	Oc. Location - City or T	own, State
Baltimore,	Department or Important: njury or oth		4 Donation 5 Other Specify: Kings Me	moriae tack Fel	2,3008 4	eballow)	MARYLAND
Bal	Departi Importinjury	•	21 Ingrature of Funeral Service Licensee 22. N	ame and Address of Facility AREY M. WITHAEE FOS W. FRANK	Funera		11229
	ician dical		23a. Part I. Enjer the disease, or complications that caused the death. Do not enter the failure. I st only one cause on each line.	mode of dying, such as cardiac or	respiratory arrest, si	hock, or heart	Approximate Interval Between Onset and
	niner		Immediate ause (Final disease or condition resulting in death)  a. Hypertensive Atherosclerotic Cardic Due to (or as a consequence of):	vascular Disease			Death
1		<u>.</u>	Sequentially list conditions, if b				
	-	Examine	Enter Underlying Cause (Disease or injury that initiated events				
cuted	und transit		resulting in death) Last  Due to (or as a consequence of):  d.				
<b>60,</b> ate be exe	physician and the burial - transit	Medical					
6876 ertificate	fing phy			al death 3 Ectopic pregna		23d. Date of delivery  Month Da	y Year
Box 687	the attending	Physician/	Pregnant at time of death	er (Specify)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	ned hy t	by Ph	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.		co use contribute to th	
ds, F	been signed hould be deta	ed	diabetes		1 Yes 2	No 3 Proba	bly 4 Unknown psy findings available
ecor he law r	ite has b ige 2 sh	ompleted			autopsy performed	prior to coud? death?	npletion of cause of
tal B	certificate has ector, page 2 s	Bec	25. Was case referred to medical examiner?	26.Place of Death (Check	1 Yes 2 ✓	No 1 Yes	2 No
Division of Vital Records, tal or Attending Physician: The law requirer after death.	After this uneral dir	위	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient  27. Manner of Death  28a. Date of Injury (Month, Day, Year)  (Month, Day, Year)		g Home 5 Resi	idence 6 Other:	
ion (ttendin	tor: A	ertification:	1 Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2 No	20d. Describe now (	injury occurred	
Divis alor A	al Direc		3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street,	factory, office building, etc.	28f. Location (Street or Town, State)	t and Number or Rura	Route Number, City
Hospit 24 hour	To the Funeral Dir completely filled in	0	29a. Certifier  Coneck only  Certifying Physician: To the best of my knowledge, death occurre	d at the time, date and place, and	due to the cause(s) a	and manner as stated	
To the	To the	Medical	one)  2 Medical Examiner: On the basis of examination and/or investigation and or and practice and trial of certifier.  29b. Signature and title of certifier.	n, in my opinion, death occurred at	the time, date and p	lace, and due to the ca	
			Signature and time of certifier	29c.License number O.C.M.E.		d. Date signed <i>(Monti</i> Inuary 29, 2008	n, Day, Year)
		-	30. Name and address of person who completed cause of death (Item 23a)	<u> </u>	30		
	Sta	ate 3	David Fowler M.D. Chief Medical Examiner 111 Penn Stree  31. Date filed (Month, Day, Year)  \$2. Registrar's Signature	et, Baltimore, MD 21201			
	enistr		15 LO 0 2000				

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

within 24 hours after death To the Funeral Director: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and time of certific 29d. Date signed (Month, Day, Year) P21190 01-25-2008 6+1 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) Greene Street Ballimore, MD 21201 10 Anne trosch Ν. 31. Date filed (Month, Day, 0 2008 32. Registrar's Signature State Registrar

	1 = For State Registrar	BARA C. CATALFAMO  by Name (If not institution, give street and number)  L MARIS HOSPICE  Security Number  09-0172  Security Number  1	tificate of			giene Reg. No. 2008 02246					
	Decedent's Name (First, Middle, I	Last)					2. Date of Dea	th	3. Time of Death		
ician dical							JAN.	23, 2008	8 12:25 ам		
niner	4a. Facility Name (If not institution, g STELL MARIS HOSP]				4b. City, Town, o	or Location of Death	n	4c. County of De	eath ALTIMORE		
al		. Sex 7. Ag		rthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	) 9 F	Birthplace (State or Foreign		
or	220-09-0172	1 L M 2 LXF	91	Yrs.	Months Days	Hours Min.	OCT 22	, 1916	MD MD		
			10c. City, Tow	n or Loc	cation				10d. Inside City Limits		
Director	MD N/A		BALT	IMOR	E				1 X Yes 2 □ No		
Dire	10e. Street and Number 3626 KENYON AVE				10f. Zip Code 21213		1	0g. Citizen of What	Country?		
Funeral [	11. Marital Status			13. W	Vas Decedent of F	lispanic Origin? (S	pecify Yes or No-		merican Indian,		
/ Fur	1 Never Married 2 Married	1 TYes 2 TV				an, Mexican, Puèrt  Specify:	o Rican, etc.)	Black, W			
ed by	3 X Widowed 4 □ Divorced	Year or Dates:	160	1				Specify: V	WHITE		
Completed	(Specify only highest of	grade completed)		(Give k	kind of work done  O NOT use retire	during most of wor	king	Tob. Kind of Busines	ss/industry		
Com	10			ome :	Maker			OWN HOME	3		
Be	17. Father's Name (First, Middle, La EMIL KEHL	st)					ne <i>(First, Middle, I</i> RITTER	Maiden Surname)			
2		(Type, Print)	196	. Mailing	Address (Street			r. Citv or Town. State	. Zip Code)		
	Mary Catalfamo-I	aughter			626 Keny			re, MD 212			
	20a. Method of Disposition		20b. Place o cemete	f Dispos	ition (Name of	i	Date	20c. Location - City	or Town, State		
	4 □Donation 5 □ Other (Spec	cify)	Garde			į	2/08	Baltimore	-		
	21. Signature of Funeral Service Lic	ensæ			Name and Addre			PEL FUNERA E, MD 2120	AL HOME, INC		
	23a. Part1. Enter the disease, or co	implications that caused	the death. Do						Approximate		
	Immediate Cause (Final disease or condition								Interval Between Onset and Death		
	resulting in death)	Ci.		of):	-						
ē	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequence	of):							
Examiner	cause. Enter Underlying that initiated events	C		Í							
-	resulting in death) Last										
dica		d									
n/Me	IF FEMALE:							23d Date of o	delivery		
sicial	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☑ No  23c. If yes, outcome pt pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)							23d. Date of delivery  Month Day Year			
Physician/Medical	9 Unknown 9 Unknown										
þ	25e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.								to the cause of death?  Probably 4 X Unknown		
letec							24a. Was a				
0							autops perfore	sy prior t med? death			
E	25. Was case referred to medical					26. Place of Dea			es 2□No		
Se Completed	examiner?    1   Yes 2   No   Hospital:   1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other / Specific   Other   All Nursing Home 5   Residence 6   Other   Ot								pecify) HOSPICE		
To Be Com	1 ☐ Yes 2 X No		ry 28b.		28c. Injur Wor		28d. Describe ho	ow injury occurred			
To Be	1 ☐ Yes 2 📉 No  27. Manner of Death 1 🛣 Natural 5 ☐ Pending	, , ,	27. Manner of Death  1 Natural 5 Pending 28a. Date of Injury (Month, Day Year)  28b. Time of Unitary at Work?  28d. Describe how injury occurred  1 Yes 2 No								
To Be	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not	(Month, Da	ury - At home, fa			Yes 2 □No			Rural Route Number,		
To Be	1 ☐ Yes 2 🕱 No  27. Manner of Death  1 🛣 Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Da	ury - At home, fa			Yes 2 ☐ No	28f. Location (St City or Town		Rural Route Number,		
o Be	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	(Month, Da	ury - At home, fa c. (Specify) of my knowledge f examination an	rm, stre	et, factory, office		City or Town	1, State)			

Registrar
DHMH 17 Rev 1/2001

State

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Yeăr)

JAN 3 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene' 11 (1) Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Mouta Dilaimy January 23 2008 4:00 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8314 Fairwood Drive Pasadena Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□ F 587 44 5758 70 Director Iraq August Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at Maryland Anne Arundel 1 TYAS 2 NO Director Pasadena 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 5 "naturel", or items 23e 8314 Fairwood Drive permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mentat Hygiene. The profess: If them 27 is marked other than "naturel", or items 23e any injury or other treumatic event, the Medical Examples once. 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White ρ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dermatologist Medica1 vears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Shoket Dilaimv Khayria Dilaimy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Dilaimy / Wife 8314 Fairwood Drive Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park 01/29/2008 Glen Burnie, Maryland ° 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signatu 3 of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) PSarc **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2/ 1 🗌 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3☐ DOA 27. Manner of Death
Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Medical Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

Division of Vital Records, P.O. Box 68760 within 24 hours a
To the Funeral I
completely filled

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

JAN 3 O 32. Registrar's Signature

~ (4(0) D) D

08-00764 Joanna Delgardo

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

arina Boigaras		For State	,	Certifica	te of D	eath			Reg	No.		
Physicia		egistrar . Decedent's Name (First, Middle,Last)					-		Date of Death Month	DayYear	.	Time of Death
edical Examir	er	Joanna Delgar							January 28,	2008 4c. County o		
	4	a. Facility Name (if not institution, give	street and number)			City, Town, or Lo Bethesda	ocation of L	Jeath		Montgon		
		Suburban Hospital	17.4 (1-	use last high		If Under 1 Year	If Under 2	24Hrs.	8. Date of Birth	(MM/DD/YYYY	g. Birthpla	ace (State or
Funeral	1	5. Social Security Number 6. Sec		yrs. last birth	· ·	Months Days	Hours	Min.			Foreign Country	,
Director	L		M 2 XF	37	Yrs.				06/24/	1970		y) WA
<b>A</b>	-	Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town	or Location						10	d. Inside City Limits
ow any		MD Montgor			manto						1	X Yes 2 No
Maryland 28a-f show d at once.	휘	10e. Street and Number				10f. Zip Code			100	g. Citizen of Wh	at Country	?
th the Maryland 23a or 28a-f sho notified at once.	Director	12211 Emerald Way	J			20876				Unit	ted St	tates
ith th		11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was I	Decedent of Hisp	anic Origin	? (Spec	cify Yes or No-		- American	Indian, Black,
eath w items	Funeral	1 Never Married 2 Married	Armed Forces?	No	If Yes	, specify Cuban,	Mexican, F	Puerto Ki	ican, etc.)	441116		,
fter d			If Yes, Give Year			es 2 X No				Specify:	Bla	
"natural"	d by	15. Decedent's Education (Specify or	ly highest grade comple	ted) 16a.	Decedent's	Usual Occupation tof working life.	on (Give kii DO NOT u	nd of wo se retire	rk done d)	16b. Kind of Bu	isiness/inat	Jstry
6 172 h cal E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			cal Assi				Medio	cino	
5-0036 led within 72 Hygiene. other than '	ᇍ		2		Mear				First, Middle, M	laiden Surname		
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last)				1			ta Tho			ļ
212° ould be Mental marke	o Be	Joseph Henry Dele 19a. Informant's Name/Relationship (T	ype, Print )	19	b. Mailing A	Address (Street	and Numb	er or Ru	ral Route Num	ber, City or Tov	vn, State, Z	ip Code)
MD 2 nd 2 shou alth and N m 27 is n aumatic		Margaretta Delga:		5	056 3	6th Aver	nue,	NE,_	Seattle	, WA 98	<u>8105</u>	
e, MD 21215-0036 I and 2 should be filted within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f she r traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition			of Dispositi	on (Name of cem	netery,		Date	20c. Location	- City or To	own, State
DOFC ages 1 nt of H ether		1 Burial 2 X Cremation 3		1	-	ion Servic	es (	02/10	/2008	Kent, W	ashing	ton
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumantic event, the Medical	Ì	4 Donation 5 Other Specify 21. Signature Fun al 3 vice Licer	:			me and Address						vey
Pem Pem Day	i	WIM ANTIN		м01113	508	N. 36tl	h Str	eet,	Seatt.	Le, WA	<u>98103</u>	A
Physician		23a. Part I. Enter the disease, or comparing failure. List only one cause on e	olications that caused the	e death. Do n	ot enter the	e mode of dying,	such as ca	ardiac or	respiratory arre	est, shock, or he	eart	Approximate Interval Between Onset and
edical		Immediate Cause (Final disease a	Multiple Stab Woo	unds							_	Death
aminer		or condition resulting in death)	Due to (or as a consequ	uence of):								
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):								
	Examine	cause Enter Underlying Cause (Disease or injury that initiated										
-\W =	xan	events resulting in death) Last	Due to (or as a consequ	uence of):							i	
ecuted n and r transit		d										
e e e	Medical	UNPENDED	AMENDED					_		23d. Date	of delivery	
3760 ficate b g physis		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	or pregnancy		al death 3	Ectopic	pregna	ncy	Month		ay Year
K 68 n certi endin use as	cial	past 12 months?	4 Pregnant at tir	me of death	_ =	ner (Specify)				190		
Box 687 he death certific y the attending p	Physician	1 Yes 2 No 9 V Unknow	J GIIRIOMII		-0-20112		-iin De		23e Did t	obacco use cor	atribute to the	ne cause of death?
b.O. that the ned by	by P	Part II. Other significant conditions	contributing to death t	out not resulti	ng in the u	nderlying cause (	given in Pa	III 1.				ably 4 Unknown
j, P ires tl signe d be d	d b								24a. Was	20 1000	700-00-00	opsy findings available
ords, w requir s been s should	<del> </del>								auto		prior to co	empletion of cause of
ecol he law ate has age 2 sl	Completed								1 🗸 Yes		1 Yes	2 No
tal Rection: The certificate ector, page	e C	25. Was case referred to medical examiner?					e of Death Other	_		l m	Othor	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funneral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detactory.	To Be	1 🗸 Yes 2 No		t 2 🗸 ER/			ury at Work		ng Home 5	Residence 6		
ing Pt After Tuneral	Ë	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day, Yes FOUND:	ar) FC	. Time of In	· · · · ·	Yes 2	2	Subject sta			
ttend teath	aţi	2 Accident S Pending	1 07 2000	22	36 hrs				28f. Location	(Street and Nur	mber or Ru	al Route Number, City
ivisior  Tor Attend  after death  Director:	Certification:	3 Suicide 6 Could no determin	ot be			et, ractory, office	building, o		- Tours			
Divisior Sepital or Attend hours after death meral Director:	Š	! 4 ♥ Homicide	cian: To the best of my			rred at the time of	date and ni		-		-	
ne Ho in 24 I he Fu pletely	cal	(Check only one) 2 Medical Examin	er:On the basis of exam	ination and/o	r investiga	tion, in my opinio	on, death o	ccurred a	at the time, dat	e and place, an	d due to the	e cause(s)
Di To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of certifier	and manner stated.				se number					nth, Day, Year)
	=	Jasha Y	ell a.			0.0	.M.E.			January	28, 2008	3
-		30. Name and address of person wh	o completed cause of de	eath (Item 23s	a)							
H		Tasha Greenberg MD.	Assistant Medica			Penn Street	, Baltimo	ore, M	D 21201			
1	State	OA Data Stand March Day Vestal	32. Registrar		á	9182		_				
Regi			2008	.35 10	13/10							

Division or Vital Records, P.O. Box 68760,		Baltimore, Maryland 2121
o the Hospital or Attending Physician: The law requires that the death certificate be executed		permit. Pages 1 and 2 should be filed within
vithin 24 hours after death.	iy: Mo ka	Department of Health and Mental Hygiene.
o the Funeral Director; After this certificate has been signed by the attending physician and	sic ed m	Important: If item 27 Is marked other than "
ompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	cia lic	any Injury or other traumatic event, the Me

			For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	artment of H rtificate of I			GIENE	2008	02249
· (5)	Physici	an	1. Decedent's Name (First, Middle, La	st)	-	_		2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic	al	LERESA  4a. Facility Name (If not institution, give street and number)  JOHNS HOPKINS HOSPITAL			DAWEDE		JANUARY	27	2008 ounty of Death	1:33 PM
į.	Examin	ier				4b. City, Town, or Location of Death 4c. County  BALTIMORE CITY				ounty of Boast	y or boast
	Funeral		Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birthp	lace (State or Foreign
Ŀ	Director		1 4 2 – 2 4 – 7 6 4 5  Usual Residence of Decedent	I□M 2 <b>⊠</b> F	75 Yrs.			12/2/			JERSEY
	yland now at		10a. State 10b. County		10c. City, Town or Lo	cation				1	0d. Inside City Limits
he Mar	e Mar 3a-f sh tified	ctor	MD CARRO	LL	WESTMI	NSTER					1 X Yes 2 □ No
	with the Maryland a or 28a-f show be notified at	Director	10e. Street and Number			10f. Zip Code			_	en of What Cour	itry?
	ns 23	Funeral	225 FROCK AVE	12. Was Decedent E		211 Was Decedent of H		pecify Yes or No	US - 14	A 4. Race - Americ	an Indian,
320	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fun	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2X No	Specify:	o Rican, etc.)		Black, White, Specify: WHI	
3-003p	72 hou natura lical E	ted	15. Decedent's E. (Specify only highest gra	ducation	16a. Deced	dent's Usual Occup	ation	kina	16b. Kind	f of Business/Ind	dustry
Ž	ithin ne. han "i	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	life I	NURSE	d)	Mily	HEA	TMU	
7	filed w Hygie other ti		12 17. Father's Name ( <i>First, Middle, Last</i>	4		MOKSE	18. Mother's Nan	ne (First, Middle			
a	should be nd Mental marked o	To Be		OHN DENMA	ΔN		MARIE	, ,		GINDER	
ary	ges 1 and 2 should to tof Health and Ment If item 27 Is marked or other traumatice		19a. Informant's Name/Relationship (	Type. Print)	19b. Mailin	ng Address (Street	and Number or Ru	ral Route Numb	er, City or	Town, State, Zip	Code)
% *`	and 2 lealth m 27 I	9	ORA DAWEDEIT -	DAUGHTER		RICH A					
0	Pages 1 nent of H ant: If ite ury or ot		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐	<u> </u>	20b. Place of Dispo		1	Date		ation - City or To	,
DAILIMOR permit. Pages Department of Important: If it any Injury or o	nit. Partmer artmer ortant Injury		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice			Y CREMA				ESVILL	E, MD OME, P.A.
n	Dep Imp any	0.7	I Thomas D.	Flother = 4		54 E. M.					•
*	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused one cause on each lin	e.	er the mode of dyin	ig, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		consequence of):	C. Water and E.					) UNI
	Lxammer	ja l	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):						
	uted ansit	min	Cause (Disease or injury that initiated events	-							
Ď,	an am	Examiner	resulting in death) Last	Due to (or as a	consequence of):						
09/90	icate be executed physician and s	edical		d							
			IF FEMALE:	23c. If yes, outcome p	of pregnancy				200	d Data of dollar	
.O. BOX	w requires that the death certificate be executed been signed by the attending physician and ♣ should be detached for use as the buriat-transit	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	□ Other (specify)			23d. Date of delivery  Month Day Year		
7	requires that the een signed by th nould be detache	by Pł	Part II. Other significant conditions	contributing to death bu	t not resulting in the ur	nderlying cause give	en in Part I.	23e. Did t	tobacco us	e contribute to the	ne cause of death?
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r	slcian: The law r s certificate has be irector, page 2 sh	: To Be Completed						24a. Was auto perfo 1 X Yes	psy ormed?	prior to co death?	psy findings available mpletion of cause of 2 No
NI G	cian: ertifica ector, p		25. Was case referred to medical examiner?	I face it als			26. Place of Dea				
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0	Attending Physician: r death. ector: After this certific by the funeral director, i	tion	1 ★ Natural 5 ☐ Pending 2 ☐ Accident investigatio	1 🖈 Natural 5 ☐ Pending (Month, Day Year) Inju				Zou. Describe	e how injury occurred		
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	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one)  1. Certifying Plants Certifying Certifying Plants Certifying Certifying Plants Certifying Certifyin	nysician: To the best on the basis of and manner sta	examination and/or in	h occurred at the tir vestigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time	cause(s) a , date and p	and manner as solace, and due to	tated. o the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifigr	2		29c. License	e number		29d. Date	signed (Month,	Day, Year)
			- Jugan	D		MD	66613		JAMUA	MY 27,2	008
	5		30. Name and address of person who			,					
	Sta	ite	J. DEDRICK JORDAN, MI 31. Date filed (Month, Day, Year)	32: Registra	r's Signature	STILLET, BA	LTIMORE	MD ZIZ	<b>8</b> 1		
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		for State	State of Maryland	•	te of Death		2000	02250
- 0		Registrar     Decedent's Name (First, Middle, Las	f)	Oertinica	le of Beatif	Reg. N	10.2 0 0 0	3. Time of Death
Physicia /Medic		LOUIS	Р		MOND	OI 28	2008	03.42 am
Examin	er	4a. Facility Name (If not institution, give	street and number)	4b. Cit	Town, or Location of Deat	L	lc. County of Death	
- <u>;</u> - <del>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</del>		5. Social Security Number 6. Se	x 7. Age (In yrs. last	t birthday) If Und	r 1 Year   If Under 24 Hrs.	8. Date of Birth		N/A place (State or Foreign
Funeral Director			GM 2□F 90	Yrs. Months		(Month, Day, Yea 01/07/1	918	place (State or Foreign intry) NY
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	٦٢	10a. State 10b. County		Town or Location		-		10d. Inside City Limits
the N 28a-f otific	Director	MD BALTIN	IONE DALIE		p Code	10a (	Citizen of What Cou	intry?
with a or		3113 NORTHBROOK	DUVU	101. 2	21208	, ogi	USA	, -
s 23	Funeral		12. Was Decedent Ever in U.S.	13 Was Dec		inecify Ves or No-	14. Race - Amer	ican Indian.
item item ner r	Ľ.	11. Marital Status 1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 X Yes 2 ☐ No	If Yes, sp	edent of Hispanic Origin? (S ecify Cuban, Mexican, Puer	to Rican, etc.)	Black, White	, etc.
rs aft I', or xami	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2X No Specify:		Specify:	WHITE
hou tura	ed	15. Decedent's Ed		16a. Decedent's Us	ual Occupation		Kind of Business/I	ndustry
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id 2 s Ith ar 27 is trau		SHIRLEY DIAMOND	WIFE	3113 NO	RTHBROOK ROAL	D. BALTIMOR	E. MD 2	1208
1 ar Hea tem		20a. Method of Disposition	20b. Plac	e of Disposition (N	ame of		Location - City or	
ages int of t: If it		1 ABurial 2 □ Cremation 3 □	Removal from State	ETNGTON'' 2 AMUNO CO	OCHIZUK O1/20	12000 PA	LTIMORE,	MD
it. Partme		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		AMUNU CU	ING. U1/2: and Address of Facility S(			
Department of the permana in the per		1 2 th	- V/22		REISTERSTOWN			
NEW YORK		23a Parti Enter the disease or come	bi ations that cause the death				LOVILLE	
		23a.   art1. Enter the disease,   r   my shock, or heart failure. List only	one cause on each li	DO HOT CHIEF THE III	de or dying, such as cardia	o or respiratory arrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a. Ungestive	Hear	t railie	C		4 days
/Medical Examiner		1 and 1 and	Due to Or as a consequer	nce of):	vis 10-00	n		29
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ath o	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 2 ☐ Fetal de	eath 3□Ectopic			23d. Date of deli Month	very Day Year
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hat the d by letac	F	Part II. Other significant conditions o	ontributing to death but not resulti	ng in the underlying	cause given in Part I	23e. Did tobaco	o use contribute to	the cause of death?
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law as b	lg e	Cheonic (	Itrial Fiber	Ellation	)	24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
The ate h page	Š					performed 1□ Yes 2□		8 D 100
sian: ertific ctor,	Be (	25. Was case referred to medical examiner?				ath (Check only one)		
To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria	T0 E	1 Yes 2 No		R/Outpatient 3□		Home 5 Residence	6 □Other (Spec	cify)
ng Pl fter t nera	Ë	27. Manner of Death  1. ☑ Natural 5 ☐ Pending	28a. Date of Injury 28 (Month, Day Year)	8b. Time of Injury	28c. Injury at Work?	28d. Describe how in	jury occurred	
endil ath. or: A	Certification:	2 Accident investigation		М	1 ☐ Yes 2 ☐ No			
er de	tific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home building, etc. (Specify)	e, farm, street, fact	ery, office	28f. Location (Street City or Town, St	and Number or Ru ate)	ıral Route Number,
talors aft	Cer		/					
hour noner noner		29a. Certifier Certifying Ph	ysician: To the best of my knowled the state of the basis of examination in the basis	edge, death occurr	d at the time, date and place	e, and due to the cause	e(s) and manner as	stated. e to the cause(s)
he H in 24 ihe F iplete	edical	one)	and manner stated.	_				
To 1 To 1	Σ	29b. Signature and title of certifier	1	I .	9c. License number		Date signed (Monti	
1		Deflectura,	MD		RES-000 I HOSPITI	) Jan	nuary,2	18,2008
15		30. Name and address of person who	completed cause of death (Item 2	3a) (Type, Print)		2	1	1. 2.2
10		DR APARNA G	ADEKAR.	SINA	I HOSPITI	91. OF C	BALTIM	OKE
Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signatur	e Anask	2			
Registr	rar	JAN 3 U Z	JUO president state	5				

Registrar DHMH 17 Rev 1/2001 DR AFARNA 31. Date filed (Month, Day, Year) JAN 3 0

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) \_Month **Physician** EHLERS 3. OIO TAM January 2002 30 nomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOWARD CO. HOSPITAL GENERAL Columbia Howard If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, May 11 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 577-46-3783 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at MD Howard 1 ☐ Yes 2 No Dayton Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14160 Twisting Lane 21036 USA by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1952 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2112 No Baltimore, Maryland 21215-0036 Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) automotive Elementary/Secondary (0-12) College (1-4or 5+) manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Beatley Ehlers Sr. Maude Wells 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Werber Ehlers (spouse) 14160 Twisting Ln., Dayton, MD 21036 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 1-31-08 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Dauge Haught & P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final montas Lung **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate 1☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 Matural funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 0058779 Paul Katamon, M.D. 300 Columbia, M

5

Registrar

31. Date filed (Month, Day, Year) State

PKWY. PATUXENT 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#300

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 820 A M dward lanuare 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ihmore If Under 1 Year If Under 24 Hrs. Hours Min. Social Security Number Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days 26-212-26-018. Usual Residence of Decedent **Director** Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2 ☑ No Director Immor NOa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: or items 23a or Important: If item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event. 1a 21222 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 - No 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) aINTO Improvemen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) auchter 10mmy naron 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of ad ley - Ash SING 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last SUCH Due to (or as a consequence of) Examiner burial-transit ston of The law requires that the death certificate be execu attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical d as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy detached for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 2 🗆 No the 9☐Unknown 9 Unknown nuer ums ceruncate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 **X**No 3 Probably 4 ☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 XNo 1∐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated within 2 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year) D005517 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sebastion 3023 tastern Arenne JOLa

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 21 per th 8876 2-6-08 vt.

Amend Item 21 per dr., 8875 (1970 and 1980  - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** elvin teather 20: SOFM 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner 4b. City. Town, or Location of Death Baltimore Mercy Hospital Baltimore 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 59 Yrs 219-50-0519 07/28/1948 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Bhow** rel', or Items 23a or 28a-f shov Examiner must be notified at 1**Y**Yes 2 ☐ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 211 Silver Court 21231 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc filed within 72 hours after 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No **Black** Specify: þ If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced 'naturel' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) I Hygiene. Janitor **UMBC** 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hy lant: If Item 27 is marked oth Be Joe Featherstone Favbel1 Jennings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 Silver Court Baltimore MD 21231 Josephine Featherstone 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crownsville Crematory 01/22/2008 Baltimore, MD 21. Signature of Funeral Service Licensee Evan W. Smith 22. Name and Address of Facility Vaughn C. Greene Funeral Service 4905 York Rd., Baltimore, MD 21212 Sheria Mills per dvr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SPIRATOR resulting in death) /Medical Due to (or as a consequence of) Examiner PRATICA Sequentially list can flices if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting is death), set Due to (or as a consequence of) Examiner burial-transit resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical use as the P.O. Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 No 1 ☐ Yes of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3□ DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident 24 hours after deat 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely and manner stated. To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D30142 CM 23 empleted cause of death (Item 2/3) (Type, Print) 30. Name nd address of person 21202 'ට 10 Q 31. Date filed (Month, Day, Year) 32. Angistrar's Signature State Registrar 2008

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	ryland / Depa	rtment of H					
			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	lilicate of L	Jealii	2. Date of Death 3. Time-of Death			
	Physicia	an		-				Month January	Day Year	9:50 A. M	
	_/Medic	Control of the Control	Donald Earle Fisher  4a. Facility Name (If not institution, give st			4b, City, Town, or	Location of Death	canaazy	4c. County of Death		
,	Examin	er	979 Eckard Court	,		Westmins	ster		Carroll		
ner.	Funeral	2	5, Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birtl	nplace (State or Foreign untry)	
	Director		217-01-1541	M 2□F	89 Yrs.	World 5 Days	Tiodis Iviiii.	Aug. 12	, 1918 Mar	yland	
	pu »		Usual Residence of Decedent  10a, State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits	
	laryla shov	'n	Maryland Carroll		Westmins					1 ∐Yes XX No	
	the N	ect	10e. Street and Number		Wescuillis	10f. Zip Code		10	g. Citizen of What Co nited Stat	untry?	
	with 3a or t be	اقا	979 Eckard Court			21158			nited Stat f America	es	
	be filed within 72 hours after death with the Maryland Hygiene. id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	2. Was Decedent E	ver in U.S. 13.	Vas Decedent of Hi f Yes, specify Cuba	Ispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame Black, White		
٥	after or ite mine		1 ☐ Never Married 2 ☐ Married	YYes 2 N	0	i⊓Yes XX No	Specify:	Thours, oto.,	Specify: Wh.	,	
Maryland 21215-0036	ural",	d by	3 3 X Widowed 4 □ Divorced Year or Dates: WWLI								
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7	withir ene. <b>than</b> he Me		Elementary/Secondary (0-12) 8th	College (1-4or 5+	-)	kind of work done of the NOT use retired to the NOT use retired to the NOT use retired to the NOT use			Law Enfor	cement.	
ק ס	filed wi Hygier other the		17. Father's Name (First, Middle, Last)			1	18. Mother's Name	e (First, Middle, M			
a	should be filed id Mental Hygi marked other matic event, t	To Be	Thomas Fisher				Nellie P	atterson			
a Z	iges 1 and 2 should be to to f Health and Mental I if item 27 Is marked of or other traumatic eve	-	19a. Informant's Name/Relationship (Type	e. Print)	19b. Mailir	ng Address (Street	and Number or Rui	ral Route Number,	City or Town, State, 2	Zip Code)	
Ž	1 and 2 Health 8 tem 27 Is		James R. Fisher, Sr	. (Son)	979 E	ckard Cou			Maryland		
ē.	of He of Herm		20a. Method of Disposition  XX Burial 2 □ Cremation 3 □ Re	moval from State	20b. Place of Dispo cemetery, crei	sition (Name of natory or other plac	e) Jan.	<sup>Date</sup> 28,	20c. Location - City or	Town, State	
Ĕ	Pages nent of I ant: If its ury or o	١,	4 □ Donation 5 □ Other (Specify)	Thoval from State	Woodlawn	-	2008		Woodlawn,	Maryland	
Baltimore,	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service Licensum	the.	3 3	Name and Addre Ckhardt I 296 Charn	ss of Facility Funeral C Mil Drive	hapel, P , Manche	.A. ster, Mary	land 21102	
燕	7 - 7		23a. Part1 Enter the disease, or complice stack, or heart failure. List only one	ations that caused	the death. Do not ent	er the mode of dyir	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between	
	Physician	7 1	Immortiate Cause (Final discase or condition		Domente					Onset and Death	
*	/Medical		resulting in death)	Due to (or as a	consequence of):						
	Examiner	١, ا	Sequentially list conditions, b.								
	and #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequence of):						
	and and	хап	that initiated events c. resulting in death) Last	ted events in death) Last Due to (or as a consequence of):							
8760,	ificate be executed the physician and as the burial-transit	冒田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田									
89	ficate J phy: ss the	edical	0.						1		
Box	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome p		∃Ectopic pregnanc	,		23d. Date of de		
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		Other (specify)			Month	Day Year	
0	at the by th	hys	9 ☐ Unknown					oo. Distant	pacco use contribute to	a the square of death?	
Division or Vital Records, I	gned be de	ρ	Part II. Other significant conditions con-	1	it not resulting in the u	nderlying cause giv	en in Part I.	1 \( \text{Y} \)		robably 4 Tonknown	
S	aw require s been si s should t	Completed	Persheral	Vascular	Disease			24a. Was a	n 24b. Were a	utopsy findings available completion of cause of	
Ä	sician: The law certificate has b irector, page 2 s	шо	Scolicinent	Candid	20515			autops perforr	ned? death?		
ta	lan: 'rtifica	Be C	25. Was case referre o medi . I	Cuaca	20/3/4		26. Place of Dea	th Check onl on	10		
<u>_</u>	Physic this ce al direc	To E	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1   Inpatie	nt 2 ☐ ER/Outpatie		4 ☐ Nursing H		ence 6 □Other (Spe	ecify)	
0	ng Pl		27. Mann of Death 1 LaNatural 5 ☐ Pending	28a. Date of Injur (Month, Day		Wor		28d. Describe ho	w injury occurred		
Sio	tendi eath. tor: A	catio	2 Accident investigation 3 Suicide 6 Could not be	00 00 1611			Yes 2 □ No	206 Leastles (Ct	reet and Number or R	tural Pouto Number	
$\leq$	or At after d Direction by	Certification:	4 ☐ Homicide determined	building, etc	iry - At home, farm, st c. (Specify)	reet, factory, office		City or Town	n, State)	urai rioute Number,	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		(Check only 2 ☐ Medical Examir	ician: To the best oner: On the basis of	of my knowledge, dea examination and/or in	th occurred at the ti	me, date and place opinion, death occu	e, and due to the curred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)	
	the thin 24 the F	Medical	29b. Signature and title of certified	and manner sta		29c. Licens			9d. Date signed (Mon		
<b>\</b>	wit Cot		1/4-1/-7	eleAus					TAN 24	2008	
	Λ		600		nath (Itam 22a) (Turn	Print)	2400	0	V1114. 61	, 2000	
	. /		30. Name and address of person who co	R M	(ulto 102)	1000 1	20506 Liberty 1	40 E	DORSBURG	W775 CM	
	St	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	1					
	Regist		' - IAN 3 0 2	anna Na	was de	Goods!					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

item 18 per fh 9875 1-30-08 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** 2008 6:15 telsen tha (0) /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Heights 7208 ParkHeights Age luder 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Funeral Months Days Hours 1 ☐ M 2 🗷 F 0 5 Director 08/16/ Usual Residence of Decedent Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. The Madical Examinar must be notified at Balto. 1 Yes 2 No Director MD N/A the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Baneberry USA 282 21209 Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☑No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 2 If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than \*\*, any injury or other traumatic avant in a second permitted. Elementary/Secondary (0-12) College (1-4or 5+) housewite 12 OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shiff Athraham Sarah Braunspiege ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baneberry Ct. Balto, MD 21209 Gerald Felsenthal 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Park Paramusno 01/29/2008 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician month /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause ( 15050 or it ill ) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Year in the past 12 months? 1 Tes 2 No Day 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe NONE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **Z**No 1 Yes 2 🗀 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Dther: 4 Nursing Home 5 Residence 6 Other (Specify) HS 15 Cold Ving 1 ☐ Yes 2 ☑ No 2 this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural death. 1 Tes 2 🗆 No 2 Accident within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

h

State

2401 W. Belvedere Ave. Balto. 21215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sinai

JAN 3 0 2008

31. Date filed (Month, Day, Year)

Hospital

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylan		artment of H rtificate of L			giene Reg. No. 2 (	118	02256	
	Dhysisi		Registrar     Decedent's Name (First, Middle Gary Francis	e, Last)					2. Date of Dea		Year	3. Time of Death	
	Physici /Medio		1				41 Oit Town	Landing of Dark	JANUA	RY 28,			
	Examin	er	4a. Facility Name (If not institution Saint Jose			nter	4b. City, Town, or	Location of Death	son	Baltimore			
37.	Funeral Director		5. Social Security Number	6. Sex 1 ★ M 2 ☐ F	7. Age (In yrs.	last birthday) 3 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da May 15.	y, Year)	9. Birth	nplace (State or Foreign untry)  MD	
A			Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation		·	1701		10d. Inside City Limits	
Marvia	r-f sho	tor	MD			,,	Baltimore	е				1 ⊠Yes 2 □ No	
h with the	23a or 28a st be noti	al Director	10e. Street and Number 1205 Linworth Ave	enue			10f. Zip Code	21239		10g. Citizen of	What Cou USA	untry?	
<b>036</b> ours after deat	es 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. If the the T21 is marked other than "natural" or items 23a or 28a-f show frother traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  12∑Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed F	i <b>2</b> MNo Bive		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes ※No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Mexican, Puerto Rican, etc.)  Bl.  Afr			ican Indian, ,, etc. merican	
Maryland 21215-0036 id 2 should be filed within 72 hours af		Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12)		() (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work l)	ing	16b. Kind of E			
d 21		Be Con	17. Father's Name (First, Middle,	Last)		la'	borer	18. Mother's Name	e (First, Middle,			company	
rylan Pould be		To B	Vernon 19a. Informant's Name/Relations	N. Francis		10h Mailir	ng Address (Street		rence Pea		State 7	in Code)	
2 2	ealth an n 27 Is r ner traur		Florence Francis		lan.	1205	Linworth A	venue; Balt	imore, Ma	ıryland	21239		
<b>Baltimore,</b> permit. Pages 1 ar	nent of H ant: If ite ury or oth		20a. Method of Disposition  1 ☐ Burial 2 ♣ Cremation  4 ☐ Donation 5 ☐ Other (S		n State	metro Crematory 01/30,				2008 Catonsville, Maryland			
Balt permit.	Department of Important: If any Injury or once.		21. Signature of Funeral Service	Licensee			2. Name and Addres	-	Wylie Fur Baltimore				
	nysician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition		caused the deal each line.		ter the mode of dyin	g, such as cardiac	or respiratory a	rest,		Approximate Interval Between Onset and Death MONTHS	
	Medical caminer		resulting in death)	- T	o (or as a consec EPSIS	uence of):						HOURS	
JA E	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. AIDS									YEARS	
<b>8760,</b> zate be exect	physician and s the burial-transit	dical Exa	Due to (or as a consequence of):										
rtificate	as the	/ledic	IE EEMALE.	T.						1			
I Records, P.O. Box 68760,  The law requires that the death certificate be executed.	rthe attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of delivery  Month Day								
rds, P.	been signed by the should be detached	ρ	Part II. Other significant condit	ons contributing to	death but not res	ulting in the u	nderlying cause give	en in Part I.				the cause of death?	
I Records, The law requires t	cate has bee	Completed							24a. Was autor perfo		. Were au prior to c death?	topsy findings available completion of cause of	
Vital	certificate rector, pag	Be	25. Was case referred to medica examiner?	Hoenital:			oth Oth	26. Place of Deat					
O C	ter this	n: To	1 ☐ Yes 2 No  27. Manner of Death	28a. Dat	Inpatient 2 ☐ e of Injury onth, Day Year)	ER/Outpatier 28b. Time o Injury	IL 3LI DOA	4 □ Nursing Ho	ome 5 ☐ Resi 28d. Describe			cify)	
Division or	within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director, p.	Certification:	1 Natural 5  Pendir investi 3 Suicide 4 Homicide 5  Could determ	gation not be 28e. Plan		ome, farm, str		Yes 2□No	28f. Location (S		nber or Ru	ıral Route Number,	
D Hospital o	4 hours af Funeral D tely filled in			Examiner: On the	basis of examina		h occurred at the tir						
To the	vithin 2 Fo the comple	Medical	29b. Signature and title of certifie		anner stated.	_	29c. Licens	e number		29d. Date sign	ed (Monti	h, Day, Year)	
) [			▶ 100mm MD D0063974							1/28/08			
	3		30. Name and address of person		use of death (Iter		Print) FR DRIV	F TOWS	IN MD	RYLANI	213	2014	
	Sta Registi		31. Date filed (Month, Day, Year)		Registrar's Sign		E)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 10:30 PM 24 TANUARY 2008 Herbert R. Grimm /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE ST AGNES HOSPITAL n/a If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) . Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Min. Days Hours 1**™** M 2 □ F Director 405-22-6774 11/26/1925 Kentucky 82 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Ellicott City Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with USA 21042 9400 Tiller Drive Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Mayes 2 No If Yes, Give Year or Dates: 1944-46 1 □ Never Married 2 Married 1 ☐ Yes 2 No Specify Baltimore, Maryland 21215-0036 Specify: \$ 3 ☐ Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Contracts Representative 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mental n and Menta Cynthia Rawlinson George Grimm permit. Pages 1 and 2 sh.
Department of Health and Important: If item 27 Is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9400 Tiller Dr. Ellicott City, MD. 21042 /\_Wife Mrs. Etta May Grimm 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/28/08 |Baltimore, Maryland Loudon Park Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licer 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enter ty disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List on ty he cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NON SMALL CELL WNG 2 MONTHS **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine Due to (or as a consequence of): 68760, attending physician for use as the buria Physician/Medical Box ( IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day Year in the past 12 months? ☐Yes 2☐No P.O. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ RENAL FAILURE 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has page 2 s autopsy performed? 1□ Yes 2 No certificate Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 2 ō 28a. Date of Injury (Month, Day Year) After thi 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation or Attending 1X Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No death neral Director: , filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide after within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 일 P19926 JANUARY 24,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANPREET MANGAT. 400 AVENUE, BALTIMORE CATON

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 3 0 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00744 State of Maryland / Department of Health and Mental Hygiene Ronald Phillip Green Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 27, 2008 Medical Examiner Ronald Phillip Green 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (if not institution, give street and number) 6 N/A Baltimore 320 North Gilmor Street 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Months Days Hours Country) M D 61 Male 6/27/46 Director 216-42-8474 Usual Residence of Decedent 10c. City, Town or Location 10a. State N/A MD Baltimore or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once. more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2412 Harlem Ave 21217 USA 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married African Yes Yes, Give Year Yes 2 X No specify: American Widowed Divorced <u>چ</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Fastfood Cook 8 Health and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine Reynolds Walter Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4304 Nicholas Ave, Balt., 21206 MDElizabeth McClain/sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition nportant: If its jury or other tr crematory or other place) 2/8/08 Baltimore, MD 1 X Burial 2 Cremation 3 Removal from State jo Carmel Mt. Cem Other Specif Donation 5 22. Name and Address of Facility Hari P. al Service Licensee 21. Signature of Fune Close F. ., MD 5126 Belair Rd, Balt 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. **Medical** Hypertensive cardiovascular disease Immediate Cause (Final disease .aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed attending physician and or use as the burial - trans hysician/Medical X UNPENDED perME.g876. 2/4/08 TT 23d. Date of delivery 68760 23c. If yes, outcome of pregnancy IF FEMALE: 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 Box 1 Yes 2 No 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Ö Yes 2 No 3 Probably 4 ✔ Unknown þ ₫. Completed 24b. Were autopsy findings available Records, 24a. Was an been prior to completion of cause of autopsy performed? death? this certificate has 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) the Hospital or Attending Physician; hin 24 hours after death. 25. Was case referred to medical of Vital Be examiner? Hospital: Other<sub>4</sub> Residence 6 V Other: Scene Nursing Home 5 DOA ER/Outpatient 3 Inpatient 1 ✓ Yes No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification: 1 X Natural Yes 2 Division Pending the Director: Investigation Accident 28f. Location (Street and Number or Rural Route Number, City in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d, Date signed (Month, Day, Year) 29c. License number

32. Registrar's Signature 31. Date filed (Month, Day, Year)

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Pamela E. Southall, MD

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

January 28, 2008

1045 hrs

10d. Inside City Limits

Svs,PA

Day

Approximate Interval

Between Onset and

Death

Year

2 No

Yes 2 No

State Registra

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland /		rtment of H			ene g. No. 2008	02259				
		- 1	1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death				
(de)	Physicia	_	Rosalie Glass				January	25 2008	07:10 A M				
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death	'				
			Oak Lodge Assisted Living			sadena		Anne Aru	ınde1				
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 85	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan. 02	9. Birth	place (State or Foreign intry) Romania				
	pui »		Usual Residence of Decedent         10a. State         10b. County         10c. City, To	wn or Loc	cation				10d. Inside City Limits				
	faryia sho ed at	ō	Total State			asadena			1 □ Yes 2√□ No				
	the N 28a-1 notifi	Director	Maryland Anne Arundel  10e. Street and Number		10f. Zip Code	asauena	10	)g. Citizen of What Cou	intry?				
	3a or	Ö	7753 Outing Avenue			21122		USA					
	ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi f Yes, specify Cuba		pecify Yes or No-	14. Race - Amer Black, White					
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:		Yes 2 No	Specify:	Tricari, etc.)		White				
Maryland 21215-0036	2 hou	Completed b	15. Decedent's Education 16 (Specify only highest grade completed)	Sa. Deced	lent's Usual Occupa	ation	kina 1	16b. Kind of Business/I	ndustry				
218	thin 7 e. an "r Med	ed l	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done o	)	ing		<b>.</b> .				
7	ed with ygiene ner tha ner the	5	12	-  -	lomemaker	40.14.11.11	/F: Af: d-fi	Househ	o1d				
pu	be fill stal H d oth	Be	17. Father's Name ( <i>First, Middle, Last</i> )  UNKNOWN			18. Mothers Nan	ne (First, Middle, M unknov	*					
7	d Mer narke	은		9h Mailin	n Address (Street :	and Number or Ru		City or Town, State, Z	in Code)				
<u>≅</u>	d 2 sl th and 7 is r traur				•			lle MD 2110					
ē,	Heal Heal tem				sition (Name of natory or other place	i _	Date 2	20c. Location - City or					
mo	Pages ent of nt: If I				n Cemeter	, 04		len Burnie	, Maryland				
Baltimore,	Departm Departm Importal any inju		21. Signature of Funeral Service Lic Insu  22. Name and Address of Facility Stallings Funeral Home, 3111 Mountain Road, Pasadena, MD 21122										
	205 2		mad f						122 Approximate				
	Physician	2 }	23a. Part l. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition										
	/Medical		disease or condition resulting in death) a. Due to or as a consequence	of):					109PALT				
	Examiner		Sequentially list conditions. b. Demen	ha					1046ars				
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ce of):									
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Box	ath ce ttendir or use	an/I	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pr pregnancy 1 □ Live birth 2 □ Fetal dea	3c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 3 □ Ectopic pregnancy					very Day Year				
P.0.	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	1  Yes 2	1 5∟	Other (specify)								
s, P.	s that in ned by	by Ph	Part II. Other significant conditions contributing to death but not resulting	g in the ur	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?				
ord	equire en sig ould b	ed b					1 □ Y€	es 2 <b>1 N</b> 3 □ Pr	obably 4 Unknown				
Division or Vital Record	The law requires that the death certific the has been signed by the attending prage 2 should be detached for use as	Completed					24a. Was autops perform	prior to death?	topsy findings available completion of cause of				
ta	an: T	Be Co	25. Was case referred to medical			26. Place of Dea	1  Yes ath Check onlon	e 1 □Yes	21010				
<u>-</u>	nysici nis cer direc	To B	examiner? 1   Yes 2   Hospital: 1   Inpatient 2   ER/	Outpatier	nt 3 DOA Oth	er: 4□ Nursing H	lome 5 ☐ Reside	ence 6 Sther (Spe	city) juins				
n o	ng Pł fter th meral		27. Manner of Death 28a. Date of Injury 28i 1 ☑ Natural 5 ☐ Pending (Month, Day Year)	b. Time of Injury	Wor		28d. Describe ho	ow injury occurred	)				
sio	tendi leath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At home,	farm etr		Yes 2 □ No	29f Location (Ct	reet and Number or Ru	um I Poute Number				
Divi	l or At after d Direc	Certification:	4 Homicide determined determined building, etc. (Specify)	, iaiiii, sii	eet, factory, office		City or Town	n, State)	nai noute Number,				
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowler (Check only one)  2 Medical Examiner: On the basis of examination and manner stated										
	ithin 2 or the ormple	Med	one) and manner stated.  29b. Signature and title of certifier		29c. Licens	e number	2	9d. Date signed (Mont	h, Day, Year)				
	⊢ ≶ ⊢ ŏ		\$ 5 Clear Solute		0:	20091		1/25/0	8				
	1		30. Name and address of person who completed cause of death (Item 23	a) (Type,	Print)	Vn	0 //	12	1.1 - 1.				
	8		31. Date filed (Month, Day, Year)  32. Registrar's Signature	991	son Pan	F Dr	w , we,	Durnie	219, 2106				
2	Sta Regist		JAN 3 0 2008					•					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 12:50 AM oldmar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Medical Baltimore Mercy 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) 7 1**X** M 2□F Days 213-28-6090 90 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a State 28a-f show ral", or Items 23a or 28a-f shore Examiner must be notified at FL PALM BEACH PALM BEACH 1 TYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Pages 1 and 2 should be filed within 72 hours after death with tent of Health and Mertial Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 2
ury or other traumatic event, the Medical Examiner must be n 2000 SOUTH OCEAN BLVD., APT. 2015 33480 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [XYes 2 ☐ No If Yes, Give Year or Dates: WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced WWII Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MANUFACTURER CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JACOB **GOLDMAN** ANN POTTS 1 ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is any Injury or other trau once. CARLA KATZENBERG / DAUGHTER 3211 BANCROFT ROAD, BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State HEBREW YOUNG MEN 01/28/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Malf Le 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate ha 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 💢 No 1X Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box 68760 within 24 hours after death

To the Funeral Director:
completely filled in by the

Baltimore, Maryland 21215-0036

State Registrar MD

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) ,26,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Van Sti Holl 7000

31. Date filed (Month, Day, Year) 3 0 2008

29b. Signature and title of certifier

32 Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 8 per fb 8876 2-6-08 yt State of Maryland Abepartment of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12:15P M January 28, 2008 THOMAS **JOSEPH** HENRY SR /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. | Date of Birth Months | Days | Hours | Min. | August 28,1925 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Months Days XXM 2 F 206-14-9763 Penńsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at <sup>1</sup> □Yesχ2□No Maryland Baltimore White Marsh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 8312 Poplar Mill Road USA 12. Was Decedent Ever in U.S. Armed Forces? XXX Yes 2 □ NoWW I I If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White Completed by 3XWidowed 4 ☐ Divorced "natural", permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the Medical Lonce. JANUARY 28. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department Manager Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Patrick Henry Sr Helen Agatha Reilly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7817 Highpoint Road Baltimore, Maryland 21234 Thomas Joseph Henry Jr Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State Dulaney Valley Mem Gardens | Feb 1, 2008 | Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wie efeld Funeral Home Inc Signature of Funer Service Licenses 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Gastrointestinal Hemorrhage **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dee to (or as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of): Box 68760; Physician/Medical SB IF FEMALE: esn 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a Division or Vital Records, P.O. JOSEPH signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2. No certificate 1□ Yes HOMAS 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

within 24 hours after death

To the Funeral Director:

completely filled in by the f

2008

HENR

7 State Registrar

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

4 Homicide

29b. Signature and title of gertifier

29a. Certifier (Check only one)

> 32. Registrar's Signature 1480

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD. TIMONIUM, ND 21093

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 1130108

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician LINWOOD EARL HINES unlary 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number Age (In vrs. last birthday) **Funeral** Days 6/5/1955 52 NORTH CAROLINA Director 245-98-9335 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 1 XYes 2 □ No permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner πust be notified. MD PG BOWIE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16435 PLEASANT HILL COURT 20716 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Never Married 2☐ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MACHINE OPERATOR FACTORY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HERBERT LEE HINES JEAN HOWELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16435 PLEASANT HILL CT. BOWIE, MD 20716 JEAN HINES/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEM, 1/29/2008 CLINTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility STRICKLAND FUNERAL SERVICES 6500 ALLENTOWN RD. CAMP SPRINGS, MD 20748 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications t shock, or heart failure. List only one cause r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, conly one cause Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Exami Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Tyes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 X No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 | Yes 2 ER/Outpatient 3 DOA 2 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Fo the Hospital or An. Sin 24 hours after death. Ineral Director: After After Certification: (Month, Day Year) 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 29a. Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 52500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B118 GOOD LUCK ROAD LANGAM, MD 20706 ABDUL WAH ABE M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 3 0

HILES INCOCC

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day **Physician** HUNTER 500 AM JANUARY CYNTHIA 25 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTUWN BALTIMORE NORTH WEST HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Months Days Director 219-26-5624 8/4/1938 69 MD. Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene.

arked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 1816 N. Bentalou Street Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes ② No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No specifyAfrican American Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH Medical Secretary Dr.Mitchell Private Practice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Hunter Agrada LeRose Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any Injury or other trau Simone E. Logan / Daughter 3115 Northmont Rd. Windsor Mill, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Park 1/31/2008 Woodlawn, MD 22. Name and Address of Facility Wie Funeral Home of Balto. Co. 21. Signature of Funeral Service Licensee 9200 Liberty Rd. Randallstown MD, 21133 23a. Part1. Enter the disease, or complications transactions to a cause on each line.

23a. Part1. Enter the disease, or complications transactions to a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) I□Yes 2 2 No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 2☐ No Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier i <mark>🖵 Certifying Physician:</mark> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLD COURT ROAD RANDALLSTOWN MD 21133 5401

LEONARD RICHARDSON M.D. 31. Date filed (Month, Day, Year)

29b. Signatu/e and title of pertific

32. Registrar's Signature GORAGE

M.0

29c. License number

057722

29d. Date signed (Month. Dav. Year)

25 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 02264 State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 3 45 PM 2008 MORTON HYMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE 6. Sex 1 X M 2 ☐ F If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 0971471933 213-30-3795 74 Director Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4204 OLD MILFORD MILL ROAD 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1. XAYS 2 No MARINE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any injury or other treumatic event, the Medical Examinat once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE ፩ 3 ☐ Widowed 4 N Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SALESMAN INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HYMAN COOPER FRANK SYLVIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 BROWWOOD ROAD, REISTERSTOWN, MD SAMMI COHEN / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH CONG. 01/27/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 10000 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death congestive Heart fullure Physician PUVS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): ettending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Diabetes mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an peripheral vascutar autopsy performed? Disease 1 ☐ Yes 2 ☐ No 1 Yes 20 No 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

Division of Vital Records, P.O. Box 68760 al or Attending P s after death. I Director: After i d in by the funera To the Hospital or within 24 hours aft To the Funeral Die

> State Registrar

Certification:

Medical

31. Date filed (Month, Day, Year)

Robert M. Cooper

5 Pending

investigation

6 Could not be determined

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 | Homicide

(Check only one)

29b. Signature and title of certifier

MO 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

6503 PARIC ITEIGHTS

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

17303 77

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

AVE BAUT, MD 21215

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

January 24,08

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Michael Johnson Jr. 08-00712 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ ohnson Month Medical Examiner nichael 1720 hrs January 25, 2008 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death NIA University Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Days Months Hours Director 213-04-7578 Country) md. 1 M 2 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f she Director 10e. Street and Number 10g. Citizen of What Country Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces? 1 Never Married Married 2 Yes Widowed 4 Divorced If Yes, Give Year Yes 2 No specify: 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industr Completed Elementary/Secondary,(0-12) College (1-4 or 5+) event, the Medical MD 21215-0036 unemployed 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ohnson tmanda Michael 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sti Johnson 214 Ni Payson Dathmore 1 may 21223 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State Baltimore, crematory or other place) 2 Cremation 3 Removal from State 2-4-08 undalk, mi), MT. Carmer Cem Donation 5 Other Specify Signature of Funeral Service Lac 270 Fred HILTUN Pass march Balto, md. nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and fa ure. List only one cause on each line /Medical a Multiple Gunshot Wounds Death Imm ate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Finneral Director: After this exercise. Physician/Medical UNPENDED attending physician or use as the burial **AMENDED** IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Dav past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ✓ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 1 🗸 Yes No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other 1 V Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Subject shot FOUND: Natural 1 Yes 2 ✔ No Director: d in by the f Pending Jan 25, 2008 1633 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 2000 blk of West Lafayette Avenue, Baltimore, MD determined 4 V Homicide (Specify) Found in Parking Lot 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E January 26, 2008 Joisha 30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

DCME

JAN 3

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2:00 PM 2008 argaret Jan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner of Maryland Medical Center

6. Sex 7. Age (In yrs. last birthday) Baltimore University If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 ☐ M 2 🗷 F 083-34-1866 65 NEW GORK Director atober 27,1942 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show "natural", or items 23a or 28a-f shoredical Examiner must be notified at 1 (2N√es 2 No HA Harmore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21225 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🐼 No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No 3altimore, Maryland 21215-0036 Specify TICAN AMERICAN Completed by 3. Widowed 4 □ Divorced nd 2 should be filed within 72 hou alth and Mental Hygiene. 27 Is marked other than "natura ir traumatic event, the Medical E: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home maker OWN Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William 19getts tose LEE 19a. Informant's Name/Relations ip (Type. 19b. Mailing Address (Street and Number or Rural Route mber, City or Town, State, Zip Code) Department of Health an Important: If item 27 is many injury or other once. Brookland ave Battimore, MARGIAND (- Daughter) helles 20b. Place of Disposition (Name of cemetery, crematory or other place)
MEHRO CREMATORY Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation BAHIMORE, MARYLAND 3 Removal from State Feb 4,2008 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
NANCY M. WATTACE FUNERAL SERVICE
3405 W. FRANKLIN SHEET-BAHIMORE, MARYLAND 21229 21. Signature of Funeral Service Licenses allace sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ilure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Bacteremia **Physician** /Medical Due to (or as a consequence of) Examiner Osteomyelitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed decubitus ulceration attending physician and for use as the burial-tran Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**X**No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Watural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident filled in by the 6 □Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760, To the Hospital within 24

> State Registrar

22 31. Date filed (Month, Day, Year) 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Si #82. Registrar's Signature

Greene St

29c. License number

21127

Baltimore

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 02267 State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2:22 January 27, 2008 /Medical George Harold Justice, Sr. 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Examiner 1058 Ouantril Wav Baltimore n/a 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 10X M 2□ F Yrs. Director 59 6/30/48 Maryland 216-54-5223 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD n/a Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or Iteme 23a or the Medical Examinar must be a 1058 Quantril Way 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after neat of Health and Merial Hygiene.
neaf of Health and Merial Hygiene.
If item 27 is marked other than "naturel; or flea marked owen, the Medical Exercities my or other traumatic swent, the Medical Exercities 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Self Employed Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၀ George Howard Justice Theresa Justice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Karen Justice / Wife 1058 Quantril Way Baltimore, Maryland 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If its any injury or of once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 2/2/08 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Euneral Service Licen: 21229 3620 Wilkens Ave. Baltimore, Maryland u 23a. Part1. Enter the disease, or compto shock, or head failure. List only one tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PROGRESSIVE ALUTE LEVKEMIA **Physician** nos /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (u. as a consequence of). sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 □Unknown Completed 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2⊠ÎNo Other: 4 ☐ Nursing Home 5 ★ Residence 6 ☐ Other (Specify) 1 Yes Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

law requires that the death certificate be executed attending physician a for use as the burial Box 68760, P.O. certificate has been signed by the a rector, page 2 should be detached it Division of Vital Records, After this certifical funeral director. death. I Director: / filled in by within 24 hours after of To the Funeral Direct completely filled in by ö Hospital the

death with the Maryland

Baltimore, Maryland 21215-0036

1 To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Lighthamping Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 mm. MD 00047348 30. Name and address of pa son who completed cause of death (Item 23a) (Type, Print)

2008

BALTIMORE MD

DILLEAMS DOUGLAS SMITH 1650

31. Date filed (Month, Day, Year) State JAN 3 0 Registrar

29a. Certifier

Medical

32. Registrar's Signature



ITTLEET

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				partment of Health and Mertificate of Death		ene 008 02268					
П	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year ( 0.0 P					
	/Medic		William Jordan, Jr.		January	23 2008 6:30 P.M					
	Examir	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death Anne Arunde1					
			Marley Neck Health & Rehab.  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Glen Burnie  (1) If Under 1 Year   If Under 24 Hrs.	9. Date of Birth						
н	Funeral Director		214 44 9107 1\(\text{X}\) M 2\(\text{T}\) F 61 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, ) 09/03/19	(ear) 9. Birthplace (State or Foreign Country) 46 Maryland					
	ס		Usual Residence of Decedent		09/03/19	40 Hai yianu					
	urylar show	<b>1</b>	10a. State 10b. County 10c. City, Town or I			10d. Inside City Limits					
	Se-f	Sct	Maryland Anne Arundel Glen B			1 ☐ Yes 2 🖾 No					
	a or 2	吉	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?						
	eath	eral	7575 E. Howard Road  11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Spe	ocify Ves or No-	U.S.A.  14. Race - American Indian,					
(0	within 72 hours after death with the Maryland ene. then "neturel", or Items 23a or 28e-f show Its M. Jieal Exarditer rust Le notified at	Funeral Director	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.					
21215-0036	ral', o	i by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 Ñ No Specify:		Specify: White					
5-0	72 h	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of worki	ng 16	6b. Kind of Business/Industry					
121	within sne. then	mp	Elementary/Secondary (0-12)   College (1-4or 5+)	e Trimmer		Baltimore City					
2	at Hygie I other vent, III		17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma						
Maryland	should be and Mental I smarked o	To Be	William N. Jordon Sr.		ne C. Can						
ary	2 should be and Mental is marked or reumatic ev	-		ing Address (Street and Number or Rura	l Route Number, (	City or Town, State, Zip Code)					
Ž	7 in tre		Virginia Morgan / Sister 7272	Crown Road Gler	Burnie,	Maryland 21060					
ore	of He of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, critical state in the state of the s	osition (Name of practory or other place)	ate 20	c. Location - City or Town, State					
Ē	permit. Pages 1 an Department of Heali Important: If item 2 eny injury or other <u>once.</u>		'4 □ Donation 5 □ Other (Specify) Bayview	Crematory   1/25/		altimore, Maryland					
Baltimore,	permit Depart Import Import eny in		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Gor	ce Funer	al Service, P.A.					
	4 U = 9 Ot	frome municipal 4001 kitchie Highway Baltimore, Maryland									
Н			23a Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	nter the mode of dying, such as cardiac o	r respirat <i>ory ar</i> res	t, Approximate Interval Between Onset and Death					
	Pny <del>sicia</del> n /Medical	ľ	disease or condition resulting in death)	Mylmua							
P	Examiner		Due to (or as a consequence of):	(							
		Jer	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury)  Due to (or as a consequence of):								
	cuted nd ransi	Examine	that initiated events C.								
Ő,	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	I Ex	resulting in death) Last Due to (or as a consequence of):								
8760,	cate b	dical	d								
9 X	eath certific attending pl	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			and Date of delivers					
Вох	atten I for u	Physician/Medi	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year					
о. О.	the d by the ached	hysi	1   Yes 2   No 9   Unknown 9   Unknown								
	w requires that the de been signed by the s should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?					
ğ	en sig	edi	tailure to three		1 🗆 Yes	2 No 3 Probably A Unknown					
ecc	law re as be 2 sh	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of					
<u>=</u>	The sate h page	Con			performe						
/ita	vicien: The l certificate ha rector, page	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)						
of	Phys this or	. To	1		ne 5 Residence	ce 6 Other (Specify)					
O	ding F h. After funera	tlon	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	of 28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	.ou. Describe fibw	injury occurred					
Division of Vital Records,	l or Attending Physicien: after death. Director: After this certifics i in by the funeral director, I	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s			et and Number or Rural Route Number,					
	s after	Cert	4 Homicide determined building, etc. (Specify)		City or Town, S	State)					
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical (	29a. Certifier (Check only 2 Intelligence Check on Check only 2 Intelligence Check on Chec	th occurred at the time, date and place, a	nd due to the caus	se(s) and manner as stated.					
	To the He within 24 To the Fe complete	Medi	and manner stated.								
	Voit To	~	29b. Signature and fitting feetifier	29c. License number	29d	. Date signed (Month, Day, Year)					
	7		20 Name and address of a state of the state	D57028		01-25-08					
4			30. Name and address of person who completed cause of death (Item 23a) (Type	Ave #231 Anna	100 L	ND 21401					
	Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature	1 M.	yous !	110 21701					
	Registr		JAN 3 0 2008 1 2000 2000	Carles I							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Dav Year LEON ROBERT KAGARISE JANUARY 2008 26. 6:30 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2 POWDER PLACE PERRY HALL, der 1 Year | If Under 24 Hrs. BALTIMORE 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) Months Days Hours Min M 2□ F 216-38-4740 70 6/7/1937 PENNSYLVANTA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD 1 ☐ Yes 2 No BALTIMORE PARKVILLE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6816 COLLINSDALE ROAD 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 → No Specify. Specify: 3 ☐ Widowed 4 ☑ Divorced WHTTE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STATE OF MARYLAND AUDIO VISUAL TECH. 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROBERT KAGARISE RUTH HOLLINGER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDY RICCI/DAUGHTER 2 POWDER PLACE PERRY HALL, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 □Removal from State DULANEY VALLEY MEM. 4 □ Donation 5 □ Other (Specify) 2/2/2008 COCKEYSVILLE, MD CAPPENS 2. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List drily one cause on each line. Immediate Cause (Final disease or condition resulting in death) henic Due to (or as a consequence of): ona Gequentiany fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24a. Was an

Physician /Medical Examiner

attending physician

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After

the Director:

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within 24 hours after To the Funeral Dire

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requires that the death certificate be executed

Box 68760.

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Records,

Division or Vital

Physician:

the Hospital or Attending

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show at

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permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other 1 any injury or other traumatic event, th

Maryland 21215-0036

Baltimore,

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7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be

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Examiner Physician/Medical ģ

as the for Completed page 2 s 25. Was case referred to medical examiner? Be

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Certification:

Medical

IF FEMALE:

1 Tes

27. Manner of Natural

2 Accident

3 Suicide

4 Homicide

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autopsy
performed
ves 2 No 1∐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

RESIDENCE

								leck offly offe)	
Hos	pital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient	3 🗆 🗆	OA	Other: 4	☐ Nursing H	ome	5 ☐ Residence	DAUGHTE 6 Mother (Specify)
	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c.	Injury at Work?		28d.	Describe how inju	ary occurred
			М		1 ☐ Yes	2 □ No			
- 1	28e Place of injury . At h	nome farm stree	t facto	my of	fico		204	Location (Ctroat a	and Number of Durel

Location (Street and Number or Rural Route Number, City or Town, State) building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29a. Certifier (Check only one)	Certifying Phy 2 Medical Exam	sic	ian: To the best of my knowledge, death occu r: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, and due to the ation, in my opinion, death occurred at the time	e cause(s) and manner as stated. e, date and place, and due to the cause
29b. Signature and	title of ecrifier			29c. License number	29d. Date signed (Month, Day, Year)

ss of person who completed cause of death (Item 23a) (Type, Print GEORGE WEINER, MD SUITE 201 9512 HARFORD ROAD BALTIMORE

32. Registrar's Signature

State Registrar

7

31. Date filed (Month, Day, Year) 3 0

5 Pending investigation

6 □ Could not be



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 25 IRVING 2008 KIND 8:35P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RUXTON OF PIKESVILLE HEALTH CTR. PIKESVILLE BALTIMORE 8. Date of Birth (Month, Day, Year) 04/21/1921 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Sex 1 M 2 D F Months Days Hours Min 212-18-5344 86 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 818 STURGIS PLACE 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Dayes 2 □ No ARM If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married 2□No ARMY 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) **ENGINEER** CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BENJAMIN KIND LENA GOODMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MIRIAM KIND / WIFE 818 STURGIS PLACE, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW 01/28/2008 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. TUC REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) etastat Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes No 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 □ No 2 Accident

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

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Important: If item any injury or othe

Pages 1 and 2 should be nent of Health and Mental

Baltimore, Maryland

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Director

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Hospital

Physician/Medical

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Completed

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Certification: To

Medical

3 ☐ Suicide

29a. Certifier

4 Homicide

after death Director: within 24 hours a

To the Funeral I completely 0

> State Registrar

Textifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month. Day, Year) 3008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Item 23a) (Type, Print)

6565

and manner stated.

Year)

6 Could not be determined

N. Charles St

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760, signed by the a To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Vear EVELYN MYERS MARIE JAN 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CARROLL HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) WESTMINSTER CARROLL 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2**X**F 90 234-10-5493 WEST VIRGINIA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits CARROLL SYKESVILLE 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1442 BUCKHORN ROAD USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE þ 3 ☐ Widowed 4 ☒ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) SOCIAL SCLURITY College (1-4or 5+) Elementary/Secondary (0-12) CIVIL SERVICE 0 AUMINISTRATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SomAzzE ANNA ပ GABRIELETTO 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 815 CHANTER DRIVE WESTMINSTER MO 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 12/2008 JOHN'S CEMETERY 2 ELLICOTT CITY, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility IN FUN BOWN FIT & MON CO 6028 SYKESVILLE RUAD ELDERSBURG MO 21784 23a. Part I Enter the diverse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TERFORATION disease or condition resulting in death) INTESTINAL Due to (or as a consequence of): Sequentially list conditions, if a sequentially list conditions, if a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Vear 5 ☐ Other (specify) 4☐Pregnant at time of death 1 Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed 1∐ Yes 2 11No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 1 No 1 patient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20806 Musey 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nD SUITE 31. Date filed (Month, Day, Year) 33. Registrar's Signature State 2008 Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State

Registrar

CORAZON SOARES, M.D.

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31. Date filed (Month, Day, Year)

DOROTH

MOORE

A.M.

32. Registrar's Signature

2300 DULANEY VALLEY ROAD

21093

TIMONIUM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day 3:12 AM Miller January Caryl 25 2003 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NIA University of Maryland Medical 5. Social Security Number 6. Sex 7 Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 1) | Nonths | Days | Hours | Min. | July 29 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Year) 1 ☐ M 2 💢 F 056-07-8459 NY Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 □XYes 2 □ No NJ Burlington Mt. Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 114 Hooton Road 08054 USA 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Homemaker Household 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jacob Issac Guedalia Moaude Georgia Jacoby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela J. Miller (daughter) 114 Hooton road, Mt. Laurel, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jan. Date 31 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donafion 5 ☐ Other (Specify) Harleigh Cem & Crem 2008 Camden, New Jersey 21. Signature of Page al Spring Lit ense 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or shock, or heart fallure. List Approximate Interval Between Onset and Death Immediate Cause (Final actic aridosis resulting in death) Due to (or as a consequence of): a.ortic Stanosi Sequentially list conditions, if a y leading to firm data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? coronary artery disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown adiric Stenosis 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy perform acute renal tailure 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3[ Specify) 28a. Date of Injury 27. Manner of Death 28b. Time of (Month, Day Year) 1 Natural
2 Accident 5 ☐ Pending investigation

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

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Funeral

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Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Exam Physician/Medical

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Completed

Be

P

Certification:

Medical

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

attending physician and for use as the burial-transit signed by the a has

P.O. Box 68760,

Division or Vital Records,

death certificate be executed funeral

within 24 hours after death.

To the Funeral Director: After completely filled in by the funera Hospitai the

State Registrar

3 🗆 🛭	AQC	Other:	4 ☐ Nursing H	ome	5 Residence	6 □Other (
	28c.	Injury at Work?		28d.	Describe how in	jury occurred
M		1 ☐ Yes	2 🗌 No			

| XertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29c. License number MD AU4176435521678

1/25/08

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

liffuny South Greene Street, Baltimore, MD 21201 Staddard

31. Date filed (Month, Day, Year) JAN 3 0 2008

6 ☐ Could not be

determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Division or Vital Records, P.O. Box 68760,

		Plea	se Type or Pri					-		_		
		1 - For State Registrar		aryland / L		artment of F			giene Reg. No.	2008	02274	
Physic /Medi		1. Decedent's Name (First, Middle Joan M.	Muraoka					2. Date of De Month Januar	Day	2008	3. Time of Death 07:45 AM	
Examir	ner	4a. Facility Name (If not institution 700 D Street  5. Social Security Number		ge (In yrs. last bir	thday)	4b. City, Town, o	asadena			Anne Ar	unde1	
Funeral Director		215-30-3120 Usual Residence of Decedent	1□M 2反F		Yrs.	Months Days	Hours Mir	). (Month, Da	9. Year) 04 19:	Con	place (State or Foreign intry) MD	
Maryland F show fied at	tor	10a. State 10b. County  Maryland Anne	e Arundel	10c. City, Tow	n or Lo		sadena		10d. Inside City Limits 1			
h with the 3a or 28a st be notii	Funeral Director	10e. Street and Number 700 D Street		.l		10f. Zip Code 21122				10g. Citizen of What Country?  USA		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:		1	Nas Decedent of H f Yes, specify Cuba	ispanic Origin? ( an, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)		4. Race - Ameri Black, White	can Indian,	
in 72 ho "natur ledical i	Completed	15. Decedent (Specify only highes	t grade completed)		Deced (Give life. L	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of w	d of Business/Ir	ndustry			
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and 2 shalth and 27 is n		19a Informant's Name/Relationsh Linda M. Baker	daughter (daughter	.		D Street				Town, State, Zi	p Code)	
ages 1 ant of He tr. If Item	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		20b. Place of cemete	f Dispo	sition (Name of natory or other place	æ) Jar	Date 31	20c. Loca	ation - City or T		
permit. P Departme Importan any Injun		All Donation 5 Other (Specify)  Metro Crematory Inc. 2008  Baltimore, Maryland State of Funeral Service Vidensee  22. Name and Address of Facility Stallings Funeral Home, 3111 Mountain Road, Pasadena, MD 21122										
Physician /Medical Examiner physician and physician and the prival-fransit	Examiner	23a. Part1. Enter the disease, or shock, or heart hilure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c.	a consequence	of):	Come		ac or respiratory a	rrest,		Approximate Interval Between Onset and Death	
The law requires that the death certificate base been signed by the attending physic bage 2 should be detached for use as the base.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death		Ectopic pregnancy			23	d. Date of deliv	rery Day Year	
quires that the de in signed by the a uld be detached f	by	Part II. Other significant condition	ns contributing to death b	ut not resulting in	n the un	nderlying cause give	en in Part I.	23e. Did t	^		the cause of death?	
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ysiclan: The is certificate hidirector, page	To Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{No} \)	Hospital: 1 ☐ Inpatie	ent 2 ☐ ER/Ou	tpatien	t 3□ DOA Othe		eath (Check only o		□Other (Speci	(fv)	
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director;	Certification: T	27. Magner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation See Blace of in	y Year) I	Time of njury	Worl		28d. Describe	how injury	occurred	al Route Number,	
ipital or / ours after eral Dire		4 Homicide determi	building, ei	c. (Specify)			ne date and plac	City or To	wn, State)			
o the Hos ithin 24 ho o the Fun ompletely	Medical	(Check only 2 Medical I	xaminer: On the basis of and manner st	f examination an	d/or inv	vestigation, in my o	pinion, death oc	curred at the time,	date and p	signed (Month,	to the cause(s)	
F \$ F ŏ		30. Name and address of person v	han h	eath (Item 23a)	Tyne "	De		5	Jam	nary	28,2008	
Sta		Y valui Sh 31. Date filed (Month, Day, Year)	Marka 32. Registr	205 ar's Signature	Asar.	tospital	'DV, (	Glen A	w	ie, o	21061	
Registr	ar	JAN 3 U &	008	1980	A STATE OF THE PARTY OF THE PAR							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Martha Mosher anyary 04:55 AM 26. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Moryland Medical Center Universityof Baltimore N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X□ F 260-32-9635 Director 80 July 04 1927 GA Usual Residence of Decedent 10a. State 10b. County ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☒ No Marvland Anne Arundel Brooklyn Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32 Rene Avenue 21225 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ White Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygiens Important: If Item 27 Is marked other the any Injury or other traumatic event, the ones. Custodian Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mattie Will Jordan Sarah Ε. Walden ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Mosher 7797 East Shore Road, Pasadena, MD 21122 (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date () 1 20c. Location - City or Town, State Feb. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Cemetery 2008 Davidsonville, Maryland 21. Signature of Funeral Service Licens Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the dise shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one lause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner Pulmonar UNENOVO Idiopathic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a surresquence of) lor Attending Physiclan: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by stenosis 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performe 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. AU4176435416662 January 26.2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

HUR MO

32. Registrar's Signature

5. Gleene

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Baltimore

21201

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Lew Year Magazine Month 1158 AM 27 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Core Cente Johns Hopkins Baynes Beltmure Baltmore 5. Social Security Number 6. Sex 1 M M 2 ☐ F If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 03/03/1918 **Funeral** Days Hours Director 215-10-3065 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Madical Examiner must be notified at 1 Tyes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4204 OLD MILFORD MILL ROAD or iteme 23a 21208 USA death Funerai 12. Was Decedent Ever in U.S. Agned Forces? 1 ☑ Yes 2 ☐ No If Yes Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after on Hygiene.

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other than "natural", or itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE by 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be file ment of Health and Mental Hy tent; if Item 27 is marked oth jury or other traumatic event Be HARRY MAGAZINER ANNA KOMENDANT ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GARY MAGAZINER / 12305 HIGH STAKES DRIVE, REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ite
any injury or ot + ABucial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW REISTERSTOWN, MD 01/28/2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral 5-rvice Licen-22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 remin Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sepsis Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death. Indown Due to (or as a consequence of): Box 68760, Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 2 No director. Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending efter death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours e To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical mpletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/17/2008 D 65807 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Five XA This HYPKIN'S

State Registrar

23,02 32. Registrar's Signature 31. Date filed (Month, Day, Year)

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avant. The Medical Examinar must be mailtied at

Baltimore, Maryland 21215-0036

Physicia /Medic Examin

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To the Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

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		1 - State Registrar	e of Maryland / Dep <i>Ce</i>	artment of Heal rtificate of Dea		Reg. No.	)8 022	1 1
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	rai	3300 Mc Elderry S	<i>.</i>	21205		u.	J. H.	
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ouce		21. Signature of Funeral Service Licensee	Tilan 1	2 Name and Iddress of	buggars, tu	1	21217	
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an		Immediate Cause (Final disease or condition	on each line.	5	( .	11 Car	Interval Betw Onset and D	eath
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•	Com				a p	erformed.	death?  1 Yes 2 No	use or
	Be	25. Was case referred to medical examiner?			Place of Death (Check or	nly one)		11
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	tion	1 Natural 5 Pending investigation	ate of Injury Month, Day Year)  28b. Time of Injury	Work?		L.	17	
	ifica	3 Suicide 6 Could not be	lace of Injury - At home, farm, st	<del>'</del>	28f. Location	on (Street and Num	nber or Rural Route Numb	oer,
	Cert	4 Nonicide	uilding, etc. (Specify)	NA	City of	Town, State)	NA	
	icai	(Check only 2 Medical Examiner: On the	the best of my knowledge, deat ne basis of examination and/or in	th occurred at the time, da	te and place, and due to death occurred at the tir	the cause(s) and n	nanner as stated.	
	Medical Certification: To	29b. Signature and title ovcertified	nanner stated.	29c. License num			ed, (Month, Day, Year)	
		1 STATE OF	TAGENT	Mariba	O(1/1607	E/	130/08	
\		30. Name and address of person who completed	cause of death (Item 23a) (Type.	Print)		9 (	30/00	
		Edward M. Sta	Aford, un	D TI	Thus Ho	plais	Outpat	ren
Sta	-	31. Date filed (Month, DJANear) 0 2008	2. Redistrar's Signature	Acres C	for kn;	601 1	s- Caroling	5
istr	ar		**	- (	Salpin	ore 1	ml) de	18

Registrar

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State of Maryland / Department of Health and Mental Hygien ? For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 26,2008 7:00p MICHAEL THEODORE PENNOCK Januarv /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1617 Burnfield Road Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | March 25, 1925 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday. 5. Social Security Number **Funeral** Pennsylvania 1X M 2□ F 204-16-9732 82 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits r 28a-f show 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2√2 No Director Maryland Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be a 1617 Burnfield Road 21237 U.S.A. death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 TYP'es 2 □ No If Yes, Give Year or Dates: WW 11 14. Rece - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🍇 ☐ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) n 27 is marked other than "t traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Construction 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Michael Pennock Veronica Sakole 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If item 27 Is any injury or other trains Roseayn Reid (Daughter) 105 Governors Way South Queenstown Maryland 21658 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State

| Donation 5 State (Specify) Finton State 1-30-08 Dulaney Valley Mausoleum Timonium Maryland permit. ignature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. once 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner TAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of The law requires that the death certificate be executed Exam Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760,<sup>(</sup> Completed by Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dinknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed? 1□ Yes 2 No or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No M death. after death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide filled To the Hospital within 24 hours a

To the Funeral C

completely filled 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29b. Signature and title of certifier nd address of person who completed cause of death (Item 23a) (Type, Print) 12 32: Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 26 **Physician** 2008 Cleo Wedson Powell Рм January 3:45 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Pikesville
Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Under 1 Year | Min. | Month, Day, Year)

4-14-1934 Milford Manor Nursing Home Baltimore Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**√** M 2□ F 73 Director NC. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1√ Yes 2 No Director MD n/a Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 1641 N. Bentalou Street 21216 USA filed within 72 hours after death v Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: African-American þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ed other than " event, the Med Elementary/Secondary (0-12) College (1-4or 5+) Brickmason Armeni Construction 10th permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other i any injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Powell Willie Lou Loftin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1641 N. Bentalou Street, Baltimore, MD 21216 Gladys Powell/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Druid Ridge Cemetery Pikesville, MD adge Cemetery 2/1/2008 Pikesville, MD

22. Name and Address of Facility Willie Funeral Fame P.A of 3alto. Go. 4 Donation 5 Other (Specify) 21. Sign ture of Funeral Service Licensee Troda 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that baused the shath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** noners disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be execut Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ed by the atter 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was a... autopsy performed? Yes 2 No 1∐ Yes Physiclan; funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of cer 8

Registrar DHMH 17 Rev 1/2001

State

30. Name and

31. Date filed (Month, Day, Year)

X38 Greene Tree Rd 21208

se of death (Item 23a) (Type, Print)

To the Funeral within 24

5

31. Date filed (Month, Day, Year) State Registrar

32 Registrar's Signature

Assistant Medical Examiner

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 25, 2008

0

3

30. Name and address of person who completed cause of death (Item 23a)

2008

29b. Signature and title of certifier

Melissa Brassell, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Year **Physician** PACH JANUARY 12:30 PM 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** RANDALLSTOWN NOTOTHWEST HOSFITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F 218-45-6700 81 Director 12/21/1926 UKRAINE Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 1 ☐ Yes 2 X No Director BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ortant: If Item 27 Is marked other than "natural", or Items 23a or Injury or other traumatic event, the Medical Examiner must be a 11106 BASKERVILLE ROAD 21136 UKRAINE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 📉 No
If Yes, Give
Year or Dates: within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITEģ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CLERICAL FACTORY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi Be NAUM RADVEL ပ CLARA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an Item 27 Is I GENNADIY PACH / SON 11106 BASKERVILLE ROAD, REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW 01/28/2008 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listically one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARCINOMA **Physician** ENDOMETRIAL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a prinsequence of Examine be executed burial-transit and A Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe certificate 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient ပ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 ☐ Could not be 3 Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funeral 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c, License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIRCEA TO TOR

32 Registrar's Signature

NOSTITULEST HOSPITAL

JAN 3 0

31. Date filed (Month, Day, Year)

D543TZ

5401 OLD COURT ROAD RANDALLSTOWN

J-ANUARY

MD

26

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per dvr 88/5 1-30-08 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2231 PM PROCOPIS PROCOPIOU 2008 /Medical PANUARY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner N/A JOHNS HOPKINS BAYVIEW MEDICAL BALTIMORE 8. Date of Birth (Month, Day, Year 02/24/1946 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 216-68-4602 61 CYPRUS Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show la or 28a-f shi t be notified a MD. N/A BALTIMORE 1XYes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8015 WYNBROOK RD. 21224 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 10 1 ☐ Yes 2 X No WHITE Specify <u>م</u> Specify. 3 Widowed 4 Divorced "naturai" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) AUTO 6TH MACHANIC traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KYRIACOS KRYIACOU CHRISTELLA ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 DAFNI PROCOPIOU/WIFE 8015 WYNBROOK RD. BALTIMORE, MARYLAND 21224 27 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If II any Injury or c 1 Burial 2 Cremation 3 Removal from State OAK LAWN CEMETERY 01/26/2008 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signatur Fune I Service Lice 1966 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Part1. Enter the disease shock, or heart failure. ist any one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finadisease or condition resulting in death) **Physician** /Medical nce of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-trar P.O. Box 68760, physician Physician/Medical the as IF FEMALE: nse s 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performed? page 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ▼ Yes 2 No funeral director, 26. Place of Death (Check only one, Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check on one) within 2. 29d. Date signed (Month Day 2008 29b. Signatu

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and address of person who come

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08-00458 Miguel Armando Retana Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 02283

		- For State Registrar	Certifi	cate of De	eath		Reg	. No.	0 0 = =		
FirySiciani							Date of Death     Month     Date of Death	Day Year	3. Time of Death 1541 hrs		
ledical Examii		Miguel Armando	Retana	Ab C	Tity Town or I	ocation of Death	January 16,	2008 4c. County of Deat			
		4a. Facility Name (if not institution, give stree side of 1305 June Road	t and number)		alethorpe	location of Death	1	Baltimpre Co			
Funeral		Social Security Number 6. Sex	7. Age (In yrs. last b		Under 1 Year	If Under 24Hrs	s. 8. Date of Birth	(MM/DD/YYYY) 9. Bi	rthplace (State or		
Director		Unknown 1 M 2	2□F 21	Yrs.	fonths Days	Hours Min	i.	Forei	<sup>gn</sup> Duntry) <b>Texas</b>		
	ŀ	Unknown Usual Residence of Decedent					Nov. 3,	1986	Texas		
' any		10a. State 10b. County	10c. City, Tow	vn or Location	·				10d. Inside City Limits		
Aaryland 28a-f show any 1 at once.	ō	Maryland Baltimore	Balt:	imore					1 Yes 2 X No		
Mary 7 28a- cd at	Director	10e. Street and Number		10	f. Zip Code		10g	log. Citizen of What Country?			
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ath wi	Funeral	1 Never Married 2 Married	Vas Decedent Ever in U.S. urmed Forces?			mexican, Puerto	pecify Yes or No- Rican, etc.)	White, etc.	rican Indian, Black,		
ter de		3 Widowed 4 Divorced If Yes,	Yes 2 X No Give Year	1X Ye	s 2 No	specify: Mex	cican	Specify: W	hite		
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withir jene ner th		11		Cook		10 Martin and Allana	e (First, Middle, Ma	Restaura	nt		
filed Il Hyg ed oth	Be C	17. Father's Name (First, Middle, Last)  Miguel  I	lores		[ ]	Crisant		ana			
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-15th maire event, the Medical Examiner must be notified at once		19a. Informant's Name/Relationship (Type, P	er, City or Town, Stat	te, Zip Code)							
MD nd 2 sho alth and m 27 is aumatin	7	Crisanta Retana (Mo	023								
nore, MD 21215-0036 ges I and 2 should be filed within 72 nt of Health and Mental Hygiene t: If item 27 is marked other than ' other traumatic event, the Medical	ı	20a. Method of Disposition  1  Burial 2 Cremation 3 Re		e of Disposition		netery,	Date	20c. Location - City of	or Town, State		
Baltimore, permit. Pages I an Department of Hee Important: If itel		1 X Burial 2 Cremation 3 Re 4 Donation 5 Other Specify:	moval from State Sout	y 1/2	23/08 Pearland, TX						
Baltimo permit. Page Department o Important: injury or ott	Ì	21. Signature of Funeral Service Licensee		rk Funeral Home							
Physician /Medical	st, snock, or near	Approximate Interval Between Onset and Death									
taminer		Immediate Cause (Final disease or condition resulting in death)  Due to	ging (or as a consequence of):								
		Sequentially list conditions, b.	(**************************************								
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λχ <u>-</u>	if any, leading to immediate cause. Enter Underlying Cause (Dicease or hypry that Initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):										
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760, cate be execut physician and he burial - tran	Medical	UNPENDED AME	ENDED								
		23b. Was decedent pregnant in the	If yes, outcome of pregnan Live birth		teath 3	Ectopic pregr	nancy	23d. Date of delive Month	ery Day Year		
Box 68 death certif he attending d for use as	icia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)									
Records, P.O. Box 687. The law requires that the death certificate has been signed by the attending page 2 should be detached for use as I	Phys	1 Yes 2 No 9 Unknown 9	Unknown	or a to the condi	1.1	duranta Barti	220 Did tob	acco uno contributo	to the cause of death?		
P.O.	by F	Part II. Dther significant conditions contr	ibuting to death but not resul	ting in the unde	eriying cause g	jiven in Part I.			robably 4 Unknown		
ords, P.C w requires that is been signed b	ted		<del></del>				24a. Was a		autopsy findings available		
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on of Vital Records, ending Physician: The law requirath. or: After this certificate has been sithe funeral director, page 2 should the funeral director, page 2 should the funeral director.	Be	25. Was case referred to medical examiner?	al: 1 Inpatient 2 ER	V/Outpatient 3		Other Nurs		Residence 6 V Oth	ner: Scene		
of V ing Phy After thi uneral d	۲ ا	1 ✓ Yes 2 No 27. Manner of Death 2	8a. Date of Injury 28	b. Time of Injur		ry at Work?	28d. Describe h	ow injury occurred			
– ≛ਾਪਵੀ	ţi	5 Fending		OUND: 535 hrs	11	Yes 2 ✔ No	Subject hang	ged self from bri	dge		
Division tal or Attendi rs after death. al Director: /	ifica		8e. Place of Injury - At home		actory, office b	uilding, etc.			Rural Route Number, City		
Divis pital or At ours after d neral Direct filled in by	Certification:	4 Homicide determined	(Specify) Other (bridge	)			1305 June Roa	ate) ad, Halethorpe, MD	)		
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifying Physician: To Check only one) Medical Examiner: On the	o the best of my knowledge,								
To the To the Comp	Medical		nanner stated.		29c. Licens			29d. Date signed (A			
	_	Leveley	4.40		O.C.1			January 17, 20			
		30. Name and address of person who complete		a)							
P			· ·		treet, Baltir	more, MD 21	201				
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	· La	P. 3						
Regist		JAN 3 0 ZUUS	3	A STATE OF THE PARTY OF THE PAR	Section 1						
DHMH 17 Rev 1/2	001			DRIGINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 23<sup>Day</sup> **Physician** Month 2000 Illiam /Medical 4c. County of Deatl 4a. Facility Name (If not institution, give street and number) Examiner Randallstown h lare 9. Birthplace (State or Country) Maryland Social Security Number Date of Birth (Month, Day, Year) **Funeral** 1 T¥M 2 □ F 212 36 9008 May 14, Director 1938 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. inside City Limits show 'natural", or items 23a or 28a-f shov dical Examiner must be notified at 1 □Yes 2 XNo Director Maryland Baltimore Reisterstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 31 Brookebury Drive Apt. B1 21136 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if item 27 Is marked other than Elementary/Secondary (0-12) 9th College (1-4or 5+) Truck Driver Courier Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elroy Ritter Catherine Schwab ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: if item 27 is any injury or other tra once. Marion Ritter / Wife Department of Health 31 Brookebury Dr. Apt. B1 Reisterstown, MD. 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park: 01/28/2008 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each time. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a prisequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examiner The law requires that the death certificate be executed physician and the purial-tr Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the o 9□Unknown 9 Unknown þ مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use con tute to the cause of death? or Vital Records, Completed by 1 ☐ Yes 2 🕶 o 3 ☐ Probably 4 ☐ Unknown 24b Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Norsing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ 26 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner 1 Death 28c. Injury at Work? 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred After Division the Hospital or Attending 1 Latural 5 Pending investigation after death.

I Director: Ald in by the fur 1 Tes 2 🗆 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral L 1 Learnifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number Signature 29d. Date signed (Month, Day, Year) MD, MPH ne and address State 2008

Registrar

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

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**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event. The Man

The law requires that the death certificate be executed and

attending physician

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within 24 hours after death. To the Funeral Director: After

To the Hospital or Attending Physician:

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Medical

the as asn jo detached þe page 2 should filled in by the funeral director,

Division or Vital Records, P.O. Box 68760,

24a. Was an autope perforn 1☐ Yes

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 2□ No

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death 1 Natural 2 Accident

5 ☐ Pending investigation 6 Could not be determined

Hospital: 1 Inpatient 2 ER/Outpatient 28a. Date of Injury 28b. Time of (Month, Day Year) Injury

3□ DOA

Other: 4 Nursing Home Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3□ Suicide

4 | Homicide

🗜 🕊 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifile MU

s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr

M. S- SUITE GET SCRAIN ItOUY GEN BURNIE 2008<sup>32. Rg</sup> 31 Date filed (Month

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	f Maryla	ind / Depa <i>Ce</i>	artment c rtificate				giene Reg. No	Z 11 11 13	02286
	0.00		Decedent's Name (First, Middle,	Last)						2. Date of De	ath		3. Time of Death
	Physici /Medio		Muriel Virginia	Sova						Januar Januar	y 30	, 2008	8:30 A M
0	Examir		4a. Facility Name (If not institution, g Gilchrist Center	give street and num For Hos	<sup>nber)</sup> pice		4b. City, Tov	vn, or Locatio	n of Death	·		County of Death Baltimor	e
	Funeral		5. Social Security Number 6	. Sex	7. Age (In y	rs. last birthday)	If Under 1 Y	ear If Und		8. Date of Birt	th v. Year)	9. Birthp	place (State or Foreign
	Director		217–30–3365	1□M 2 <b>½</b> F	72	Yrs.		.,,		10/20/	1935	Mary	land
	land ow tt		Usual Residence of Decedent  10a. State 10b. County		10c.	City, Town or Lo	ocation					1	10d. Inside City Limits
5	Mary t-f sh fied a	ţċ	Maryland Baltim	ore	M	liddle F	River						1 □Yes 2 No
The	th the or 28a e noti	)irec	10e. Street and Number				10f. Zip Co	de			10g. Cit	izen of What Cour	ntry?
(10)	death with the Maryland ams 23a or 28a-f show r must be notified at	Funeral Director	1201 Middleway		~		212					S.A.	
9	er des items ner m	ine	11. Marital Status	12. Was Dece	rces?	U.S. 13.	Was Decedent If Yes, specify	of Hispanic ( Cuban, Mexic	Origin? (Spec can, Puerto F	cify Yes or No Rican, etc.)	-	<ol> <li>Race - America</li> <li>Black, White,</li> </ol>	
)36	irs aft		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	d 1 ∐ Yes if Yes, Giv Year or Da	/e		1 □ Yes 2X	No Specia	fy:			Specify: Wh	ite
> 0-	72 hou	ted	15. Decedent's	Education		16a. Dece	dent's Usual O	ecupation	act of workin		16b. K	ind of Business/In	dustry
2008 21215-003	ithin 7	Completed by	Elementary/Secondary (0-12)	College (1	l-4or 5+)	1	kind of work d DO NOT use r			9			
<u> </u>	Hygie Hygie ther ti		10 17. Father's Name ( <i>First, Middle, Le</i>	ist)		rest	piratory	<u> </u>		(First, Middle,		pital Surname)	
$30^{\prime}$	uld be fi fental h rked ot tic ever	To Be	John Thomas Pind	,						rginia			
∠ √ √ √ √ √ √ √ √ √ √ √ √ √ √ √ √ √ √	shou and M s mar umat	-	19a. Informant's Name/Relationship	(Type. Print)				reet and Nun	nber or Rurai	Route Numb	er, City o	or Town, State, Zip	
75	and 2		Norman Sova, Jr.	(Son)							ew W	indsor,	Md. 21776
ANUAR Baltimore			20a. Method of Disposition  XBurial 2 □Cremation 3	□Removal from	State		matory or othe	r place)		ate	20c. Lo	ocation - City or To	own, State
3 1	it. Pa Intmen Intant: Injury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service ☐		M	d. Vete				/2008			rest, Md.
ANUAR Baltimore.	permi Depar Impor any ir		21. Signature of Furgation	Certace	<u></u>		1407 0	Bruzdz ld East	žinski tern A	Funera venue,	al H Ess	ome, P.A ex, Mary	iand 21221
7	ale est		23a. Part1. Enter the disease, or co	omplications that c	aused the de	eath. Do not en	ter the mode of	f dying, such	as cardiac o	respiratory a	rrest,	***************************************	Approximate Interval Between Onset and Death
	Physician	Ш	Imme tate Cause (Final disease or condition resulting in death)	_an	ret	A-s-fa+	f. 2 6	3(110	Ider	CAV	(ce)	R	mentles
7	/Medical Examiner		resolung in deality	Due to (	or as a cons	equence of):							
		be	Sequentially list conditions, it any, leading to inmediate cause. Enter Underlying Cause (Disease or injury	b. Due to (	or as a cons	equenne of):							
6.1	executed n and ial-transit	Examiner	triat iriitiateu events	C									
30°5	ficate be executed physician and sthe burial-transit		resulting in death) Last	Due to (	or as a cons	equence of):							
68760	icate be physicians the buri	dical		d									
Box (	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			7					23d. Date of delive	ery
Ω.	death	Physician/Me	in the past 12 menths? 1 ☐ Yes 2 ☑ No		oirth 2 □ Fo nant at time o		⊒Ectopic pregr ⊒ Other <i>(specil</i>					Month	Day Year
P.O	that the de	Phys	9 ☐ Unknown  Part II. Other significant condition			aculting in the u	ndadiina anin	o whom in Day	41	220 Did t	ahaasa .	una contributa to ti	he cause of death?
Records.	w requires that the death certification is been signed by the attending should be detached for use as	d by	ran ii. Other significant condition	s contributing to de	saur but not r	esulting in the d	inderlying caus			1 <b>200</b> . Did (			bably 4 □Unknown
$\tilde{\mathscr{A}}$	law as b	Completed								24a. Was		24b. Were auto	opsy findings available ompletion of cause of
	D after □	Com								perfo 1□ Yes	rmed2 2 No	death?	2 □ No
Z Z	Physiclan: this certifica	Be	25. Was case referred to medical examiner?	Hospital:				Other:		(Check only o			11 -0.70
5 5	Phy rald	<u>1</u>	1 Yes 2 No  27. Manner of Death	28a. Date	of Injury	ER/Outpaties 28b. Time of		Injury at Work?		ne 5 ☐ Residente Bd. Describe I		6 Other (Special for occurred	W) Hospice
- ioi	Attending r death. ector: After by the fune	atior	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat		th, Day Year,	Injury	М	Work? 1 ☐ Yes 2	□No				
(H)	I or Attend after death Director: \	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be ed 28e. Place buildi	of injury - At ng, etc. (Spe	home, farm, sti	reet, factory, of	fice	2	8f. Location (3 City or Tox	Street ar wn, State	nd Number or Rura e)	al Route Number,
20	To the Hospital or Attendia within 24 hours after death.  To the Euneral Director: A completely filled in by the fu		29a. Certifier 1 Certifying	Physician: To the caminer: On the ba	best of my k	nowledge, deat	h occurred at t	he time, date	and place, a	and due to the	cause(s	) and manner as s	stated.
M	thin 24 the Fi	Medical	29b. Signature and title of certifier	and man	ner stated.			cense numbe				te signed (Month,	
	F.3 F.00			mythil	en.	up							
	¥		30. Name and address of person wi	no completed caus	e of death (It	em 23a) (Type,	Print)	end.	(7	Br. Do	4	m120	202
	Sta	te.	31. Date filed (Month, Day, rear)	G 19/1	egistrar's Sid	nature_	1 as :	Co Co	- U) -	,,,,,,	0 - 6		- 07
	Registr		JAN 3 0	2008	Sie de la constitución de la con	gnature	and a						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 30 AM **Physician** Month Elizabeth F. Sibiga /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Feb. 8, 1 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M **X**(**X**)F Days Hours Maryland 1936 Director 216-32-2715 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f sh notified XXYes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be 5505 Bayview Hopkins Drive 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes **A** (**X**)No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes XX No Baltimore, Maryland 21215-0036 Specify: White ģ 3XXvidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) marked other than 12 Cafeteria Worker Public Schools nd 2 should be filed valth and Mental Hygie 27 is marked other r traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked of any Injury or other traumatic ever Frederick Philip Huber Gladys Irene Elliott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 699 Sullivan Rd. Westminster, MD 21157 Beth Irene Meyers / 20b. Place of Disposition (Name of Cemelery, crematry of other place)
Maryland Veterans
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation \_5 ☐ Other (Specify) Feb 4,2008 Owings Mills, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, MD 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UNGESTIVE /Medical Due to (or as a consequence of): Examiner Securentially list nunditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and stransit The law requires that the death certificate be executed SCOURCE Due to (or as a consequence of Box 68760. Physician/Medical attending ph I for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes No 9 ☐ Unknown Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) o. the 9 Unknown by ۵ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has page 2 1∐ Yes or Vital IURSID 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes No Hospital: Inpatient P 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: Division Hospital or Attending 5 Pending investigation tniury 1 ☐ Yes 2 ☐ No death. 2 Accident neral Director: / 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

TACON

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 27, 2008 Snyder 6:45 AM M January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ellicott City Ellicott City Health & Rehab Center Howard If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 💢 M 2 🗆 F Director 07/06/1930 Pennsylvania 167-24-4587 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐Yes 2 XNo Director Sykesville Maryland Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7426 Village Road 21784 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Service Manager Automotive 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be fi permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked of any Injury or other traumatic ew ၉ William H. Snyder Mary Rozowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8720 Ridge Road Ellicott City, Maryland 21043 Lee H. Snyder - Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/29/2008 Baltimore, Maryland Bayview Crematory 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Maryland 21231 21. Signature of Funeral Service Licensee صد 23a. Part. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardwarcular Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical the as attending properties for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate 2[ Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Injury 5 Pending investigation Natural М 1 □ Yes 2 □ No within 24 hours a er dea h. To the Funeral Director 2 Accident 6 Could not be 3 TI Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier D30641 January 29 2007

The of death (Item 23a) (Type, Print)

201-105 15ack New Neck Road Ballower Maylay 2424

Denistra's Standard

State Registrar

3 0 2008

Lanch

31. Date filed (Month, Day, Year)

Sabapathe 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maryland 21215-0036

Baltimore,

or Vital Records, P.O. Box 68760,

**Physic** /Med Exami

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, St

	1 - For State Registrar		Certificate of Death Reg. No. 2008 02289							
ian	1. Decedent's Name (First, Middle, Last)	CI	ITL TNC			2. Date of Dea Month	Day	Year 2008	3. Time of Death	
cal	REUBEN  4a. Facility Name (If not institution, give st.		ILING 4b. 0	City, Town, or	Location of Death	Januar	7 ')	ty of Death	10113 1 111	
ner	UNION MEMORIAL HO				TIMORE		N	/A		
	5. Social Security Number 6. Sex 1 💢	7. Age (In yrs. las	yrs. If U	nder 1 Year ths Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 06/02/1	Year)	9. Birthp Cour		
	Usual Residence of Decedent	91				06/02/1	916		MD	
_	10a. State 10b. County N/A	10c. City,	Town or Location					1	0d. Inside City Limits	
ecto			BALTIM		-	1.	10 O't	11175 - 1 0	1 May Yes 2 □ No	
Dir	3704 N. CHARLES S	T #1501	101	. Zip Code	1218		10g. Citizen o	What Cour		
Funeral Director		2. Was Decedent Ever in U.S.	13. Was D		L & L O spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No-	14. Ra	ace - Americ	can Indian,	
y Fu	1 Never Married 2 Married	Armed Forces? 1			Specify:	nican, etc.,	Spec	ack, White, <i>ify:</i> WH]		
Completed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Education	Year or Dates:	16a. Decedent's	Usual Occupa	ition		16b. Kind of			
plet	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give kind o life. DO NO	f work done d OT use retired)	uring most of worl	king			,	
Con		College (1-4or 5+) 5+	ATT0				LA			
To Be	17. Father's Name (First, Middle, Last) BENJAMIN	SH	HILING		18. Mother's Nam	ne (First, Middle,		PIRO		
	19a. Informant's Name/Relationship (Type PEARL SHILING /		_		nd Number or Ru				·	
-	20a. Method of Disposition	20b. Plac	ce of Disposition	(Name of	ES ST.,	#15U1 Date	BALTI 20c. Location			
	1	moval from State ARCI	netery cremator. NGTON CI 10 CONG	HIZUK	01/27	7/2008	вА	LTIMO	RE, MD	
	21. Signature of Funeral Service Licenses	e AMOIN	22. Nam		s of Facility S	DL LEVIN	SON &	BROS.	, INC.	
	23a. Part1. Enter the disease, or complic	pations that caused the death		2.5				ILLE,	MD 21208 Approximate	
	shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.			yocard			00	Interval Between Onset and Death	
	disease or condition resulting in death)	Non S   E	nce of):		~		ar err		1 Дау	
<b></b>	Sequentially list conditions, b.	Coro nas		Irteru	Disc	ase			1 Day	
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque								
Exal	that initiated events c. resulting in death) Last	Due to (or as a consequen	nce of):							
Medical	d.									
/Me	IF FEMALE: 23	3c. If yes, outcome pf pregnance	cy				23d F	ate of deliv	en/	
iciar	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea		oic pregnancy r (specify)				/onth	Day Year	
Physician/	9 ☐ Unknown	9∐Unknown				100 5111				
	Part II. Other significant conditions cont	ributing to death but not resulti	ing in the underlyi	ng cause give	n in Part I.	23e. Did to		ntribute to t 3 ☐ Prol	he cause of death?	
Completed by						24a. Was a	an 24k	. Were auto	opsy findings available	
omp						autop perfo	sy med? 2. No	prior to co death? 1 ☐ Yes	mpletion of cause of 2□ No	
Be C	25. Was case referred to medical examiner?				26. Place of Dea				2010	
은	1 ☐ Yes 2 ☐ No Ho		R/Outpatient 3		4 🗆 ivursing n	ome 5 Resid			fy)	
tion:	1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury M	28c. Injury Work 1 □ \	? ′es 2 □ No	28d. Describe h	ow injury occ	urrea		
tifica	3 Suicide 6 Could not be determined	28e. Place of injury - At home building, etc. (Specify)	e, farm, street, fa	ctory, office		28f. Location (S City or Tow		nber or Run	al Route Number,	
Cer	4556									
Medical Certification:	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examine	ician: To the best of my knowler: On the basis of examination and manner stated.	euge, death occu on and/or investig	ation, in my op	ie, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and date and plac	manner as s e, and due t	o the cause(s)	
Me	29b. Signature and title of certifler	1/ 00		29c. License			29d. Date sigi	ned (Month,	Day, Year)	
	11000 X	. Vm , D.O	•	HId	438941	0	Janu	iry	24,2008	
	30. Name and address of person who con	mpleted cause of death (Item 2		lnion	Memi	orial t	tospit	al	MD	
ate rar	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	e America	1						
-ui			3							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 25 **Physician** STERN 2008 8:19 A M **GUENTHER** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL OF BALTIMORE BALTIMORE N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 07/14/1929 Birthplace (State or Foreign Country)
 GERMANY 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 045-22-9439 78 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD N/A BALTIMORE 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 USA 6317 PARK HEIGHTS AVE., #204 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No WHITE Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GUIDANCE COUNSELOR EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) STERN THEODORE NUSSBAUM JETTCHEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TED STERN / SON 6101 PARK HEIGHTS AVE., #4H, BALTIMORE, MD 20b. Place of Disposition (Name of CHEVRA CHARACTER) CHESED, INC 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 □Removal from State 5 ☐ Other (Specify) 01/27/2008 RANDALLSTOWN, MD 4 ☐ Donation Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Yhrs Immediate Cause (Final disease or condition resulting in death) **Physician** Mys cannot (morrison /Medical Due to (or as a consequence of): **Examiner** Due to (or an a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Š signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1∐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient **3**₹ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident hin 24 hours after death the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) completely and manner stated 29b. Signature and title of cortifier 29d. Date signed (Month, Day, Year) 0 108 e of death (Item 23a) (Type, Print) 30. Name and address of person who completed call Goldson 2835

DHMH 17 Rev 1/2001

Registrar

		For State	State of Maryla		artment of Hea			000	10 0220	1
*		Registrar  1. Decedent's Name (First, Middle, Las	st)	001	inoate of Bet	2. 🗆	Reg. Date of Death		3. Time of Death	-
Phys /Me	ician dical	Hally H. S	heets			Jai	nuary 7	, 2008		М
Exan	niner	4a. Facility Name (If not institution, give 901 Barnett Lane			4b. City, Town, or Loca <b>Aberdeen</b>	ation of Death		4c. County of	f Death <b>ford</b>	
Funer		5. Social Security Number 6. S 220–32–2908	ex 7. Age (In yrs	s. last birthday) Yrs.		ours Min. (/	Date of Birth Month, Day, Ye	ear)	9. Birthplace (State or Fore Country)  New York	ign
		Usual Residence of Decedent  10a. State 10b. County		ity, Town or Lo	cation		indly 30	,1,3,	10d. Inside City Lim	its
Maryla -f sho	בַּ			Aberde					1 □ Yes 2 🔀	
th the or 28a e notif	Director	10e. Street and Number			10f. Zip Code			Citizen of Wh	nat Country?	
sath wi	lara	901 Barnett Lane	#413 12. Was Decedent Ever in I	116 112 1	21001			SA 14 Page	- American Indian,	
inc, intally latter 2.12.13-0030 stand 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	hy Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ ② Vivorced	Armed Forces?  1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:		Was Decedent of Hispar f Yes, specify Cuban, M I □ Yes 2 <b>X</b> No <i>Sp</i>	exican, Puerto Ricar	n, etc.)		White etc.	
72 hour hatture	pata	15. Decedent's Ec	lucation de completed)	16a. Deced	lent's Usual Occupation kind of work done during OO NOT use retired)	unk g most of working	16	o. Kind of Bus	iness/Industry	
within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. I	OO NOT use retired)			Sewing	Factory	
e filed al Hygi other	Po C	17. Father's Name (First, Middle, Last)			18.	Mother's Name (Firs	st, Middle, Mai	den Surname	)	
ylan ould b Mentg arked	L C	Rayhor rectaile				Regina Eth				
d 2 sh th and th and 7 is m traum	1	19a. Informant's Name/Relationship (** <b>Regina Marcelli</b>		7.1	g Address (Street and I			ity or Town, S <b>21921</b>	îtate, Zip Code)	
s 1 an of Heal		20a. Method of Disposition	20b.	Place of Dispo		Date			City or Town, State	
Page ment c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Other (Specify								
permit. Pages 1 and bepartment of Health Important: If Item 27 any injury or other tr	ouce.	21. Signature of Funeral Service Licer  Ronald S. Wad	per DVK		Name and Address of altimore St				rd, 655 West 1201	
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	ath. Do not ent	er the mode of dying, su	ch as cardiac or res	piratory arrest		Approximate Interval Between Onset and Death	
Physicia /Medica		Immediate Cause (Final disease or condition resulting in death)			ry Disease				Oliget and Death	
Examine	-		Due to (or as a conse							
	no.	Sequentially list conditions, if any, leading to immediate cause. Enter underlying	Due to (or as a conse							
cecute and I-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Hyper1:	ipidemi	a					
cate be executed oblysician and the burial-transit	dical F		,		uropathy					
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregi 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Year	
s that med by e deta	hy Ph		ontributing to death but not re	esulting in the ur	nderlying cause given in	Part I.	23e. Did tobac	co use contrib	oute to the cause of death?	
equire sen sig	Pol					— Щ	1 ☐ Yes	2 □ No 3	3 Probably 4 □Unkno	wn
e law i has be	Completed					:	24a. Was an autopsy performed	pr	ere autopsy findings availa for to completion of cause o eath?	ble of
in: Th ificate or, pag	0				26	Place of Death (Ch	1□ Yes 2		☐Yes 2☐No	
lysicia lis cert directe	Š	examiner? 1 ☐ Yes 2 ☐ <b>X</b> No	Hospital: 1 ☐ Inpatient 2 [	☐ ER/Outpatien	Other	□ Nursing Home	•	e 6 □Other	r (Specify)	
nding Ph th. :: After th e funeral	Tion: T		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 \( \superset \text{Yes}		Describe how	injury occurre	d	
al or Atter after dea Director	Certification:	3 Suicide 6	28e. Place of injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office	28f. L	ocation (Stree City or Town, S	t and Number State)	r or Rural Route Number,	
ne Hospita 124 hours ne Funera Netely filler	Medical C		ysician: To the best of my kr niner: On the basis of examir and manner stated.	nowledge, death	n occurred at the time, divestigation, in my opinio	ate and place, and on, death occurred at	due to the caus t the time, date	se(s) and man and place, ar	ner as stated. nd due to the cause(s)	
To th Withir To th	M	29b. Signature and title of certifier	Pando I	/	29c. License nun <b>D38125</b>		29d.	Date signed	(Month, Day, Year)	
		30. Name an laddress of person who Steven Pondek, 1	completed cause of death (Ite	em 23a) (Type,	Print) at Riversid	e. 1321 R	Belcam Liversia	p, MD 2 de Parl	21017 kwav	
Regi	State strar	31. Date filed (Month, Day, Year)	Registrar's Sign	nature 🥒					······································	
				9						

TAVON Tren							
08-00361 UNK UNK	Please	Type or Print in Bla State of Maryland /					0 0000
	1- For State Registrar	otato or maryiana /	Certificate of Deat		Reg. N	200	8 0229
Physician Medical Examine		, Middle,Last)	• "		2. Date of Death Month Da January 13, 2		3. Time of Death 1000 hrs
1		stitution, give street and number)		Town, or Location of Dea		4c. County of Death	
Funeral	Rear of 200 blk F  5. Social Security Number		(In yrs. last birthday) If Und	MOFE  ler 1 Year   If Under 24H	Ire 8 Date of Birth/N	IM/DD/YYYY) 9. Birti	onlace (State or
Director	214-92-052 Usual Residence of Deced	.3 1 M 2 F	30 Yrs. Month		in. Tw. 30, 1	Foreign	
w any	10a. State 10b. C	<del></del>	0c. City, Town or Location				10d. Inside City Limits
inyland la-f sho	10e. Street and Number	10 //	10f. Zig	Code	100 (	Citizen of What Coun	1 Yes 2 No
Pages 1 and 2 should be filed within 72 hours after death with the Maryland beent of Health and Mental Hygiene.  Intil filem 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.		12. Was Decedent E	WE	21216		11.5,1	1
r death with or items 23 must be no	1 Never Married 2	Married Armed Forces?		ent of Hispanic Origin? ( fy Cuban, Mexican, Puer	to Rican, etc.)	14. Race - Americ White, etc.	an Indian, Black,
s after rral", o	3 Widowed 4	Divorced If Yes, Give Year	1 Yes 2			Specify: DH	rk
5-0036 ed within 72 hour tygiene. other than "natt the Medical Exar	Elementary/Secondary	n (Specify only highest grade comp (0-12) College (1-4 or 5+	during most of wo	Occupation (Give kind o rking life. DO NOT use re	etired)	b. Kind of Business/Ir	ndustry
5-0036 led within 7 Hygiene. Other than the Medica	17. Father's Name (First, M	Aiddle Leet	N/A	Tan Marka da Ala		VA	
Baltimore, MD 21215-003 permit Pages I and 2 should be filed with Oppartment of Haulth and Mental Hygiene. Important: If item 27 is marked other Injury or other traumatic event, the Med To Re Comment of the Med To Re Comm	B LRVIN A	CAMPDE// Tr	ŧ	6/14/1	ne (First, Middle, Maid	en Surname)	
Should and Me 7 is ma natic ev	19a. Informant's Name/Rel	ationship (Tile, Print)	19b. Mailing Address	(Street and Number of	r Rural Route Number	City or Town, State,	Zip Code)
e, Mi 1 and 2 Health 8 litem 27	20a. Method of Disposition		20b. Place of Disposition (Nar		Date 20	c. Location - City or	Town, State
	4 Donation 5 Ot	mation 3 Removal from State her <i>Specify:</i>	Ma TVI	1-	19-06 (	ntengu//s	MM
Baltimo permit. Pag Department Important: injury or ot	21. Signature of Funeral S	ervice Licensee	22, Name and	Address of Facility	270 FRAD	NILBANG	55 2122M
Physician	23a Part I. Enter the disea failure List only one	use, or complications that caused the	e death. Do not enter the mode	of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
/Medical :aminer	Immediate Cause (Final di or condition resulting in de	sease a. Marcotic i	utoxication and cor uence of):	aine use			Death
Į.	Sequentially list conditions if any, leading to immediat	e Due to (or as a conseq	uence of):				
Sit Saminer	(Disease or injury that initial events resulting in death)	ated C	uence of):				
secuted - transi	• [	d					
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Box 68760, e death certificate be execute the attending physician and of for use as the burial - transcript and Medical	23b. Was decedent pregnar past 12 months?	nt in the 1 Live birth	2 Fetal death	3 Ectopic pregi		23d. Date of delivery  Month Di	ay Year
). Box the death by the atter	1 Yes 2 No 9	Unknown g Unknown	5 Other (Spe	cify)			
P.O. s that the greed by e detach		conditions contributing to death b	out not resulting in the underlying	cause given in Part I.	23e. Did tobace	co use contribute to the	he cause of death? ably 4  Unknown
Records,  The law require  page 2 should by  grape 2 should be					24a. Was an autopsy		opsy findings available ompletion of cause of
Rec The la ficate h						l? death? No 1 ✔ Yes	2 No
/ital	25. Was case referred to mexaminer?	Hospital:		26.Place of Death (Chec		idence 6 🗸 Other:	Scene
of Vi ing Physi After this uneral dii	27. Manner of Death	28a. Date of Injury (Month, Day, Year	28b. Time of Injury	28c. Injury at Work?	28d. Describe how		
ivision or Attend after death. Director: d in by the f	1 Natural 5 2 Accident	Pending Investigation FNd 1/13/2	008 Fnd 10:00 am		unk		
Division o ospital or Attending hours after death. uneral Director: Afty filled in by the fune Certification:	3 Suicide 6 X 4 Homicide	Could not be	y - At home, farm, street, factory of 200 blk Harris	•	or Town, State) Baltimore	)	al Route Number, City
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Fumeral Director: After this certifi completely filted in by the funeral director, edical Certification: To Be of		ing Physician: To the best of my kill Examiner: On the basis of examin	nowledge, death occurred at the	time, date and place, an	nd due to the cause(s)	and manner as state	d.
To the HG within 24 To the Fu completely	29b. Signature and title of o	and manner stated.		c. License number		d. Date signed (Moni	

State

Registrar

30. Name and address of person who completed clude of death (Item 23a)
Theodore M. King, Jr., MD. Assistant Medical Examiner 112 Penn Street, Baltimore, MD 21201
31. Date filed (Manus Day, Jean)

29c. License number

O.C.M.E.

OCME

29d. Date signed (Month, Day, Year)

January 14, 2008

			For State Registrar	State of Maryland /		artment of He tificate of D			iene () (	38	02293
			1. Decedent's Name (First, Middle, Las	1)				2. Date of Dea Month	th Day	Year	3. Time of Death
E	Physici /Medio		Joyce Dudley Ta	ylor				January			4:45a M
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or		h	4c. County		
			Carroll Hospice		1 2 4 4 1	Westmins	ter If Under 24 Hrs	10.5	Carr		Land (State on Forman
	Funeral		5. Social Security Number 6. Security Number 11	7. Age (In yrs. last)	birthday) ( Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, Day	, Year)	Coun	lace (State or Foreign etry)
Н	Director		Usual Residence of Decedent	Λ 43				Aug 26	1964	_MD_	
	yland		10a. State 10b. County	10c. City, To						1	0d. Inside City Limits
	e-€	ctor	MD Carroll		Syke	sville					1 ☐ Yes 2 ₹ No
	3a or 28	Funeral Director	10e. Street and Number 7515 Patapsco Dr:	ive		10f. Zip Code 21784		_1	0g. Citizen of W USA	/hat Cour	ntry?
	deatl	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. \	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (S	pecify Yes or No-		e - Americ	ean Indian,
36	s after , or ite		1 ☐ Never Married 2√ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X	+	Yes 27 No	Specify:	(O 1 (OZI), O(O.)		whi	
21215-0036	hour fural	Completed by	15. Decedent's Ed	Year or Dates:		lent's Usual Occupa	tion		16b. Kind of Bu		
7.	in 72	plet	(Specify only highest gra-	de completed)	(Give	kind of work done do OO NOT use retired)	uring most of wo		warehou		,
212	d with	E	Elementary/Secondary (0-12)	College (1-4or 5+)	buy	er			warenou	SE	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "natural; or Items 23e or 28e-f ehow enty injury or other traumatic event, the Medical Exercities mast be notified at once.	To Be C	17. Father's Name (First, Middle, Last) John Thomas Dudle	ey, Sr.			18. Mother's Nat Jill Bo	me (First, Middle, . olling	Maiden Surnam	e)	
ary	should Mand Munder	۴	19a. Informant's Name/Relationship (7			g Address (Street a					Code)
Σ	and 2 salth a n 27 i		Steven E. Taylor			Patapsco	Dr., Syl	366			
altimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from State ceme	tery, cren	sition (Name of natory or other place			20c. Location -		
Ē	Pag tent: Jury o		4 ☐ Donation 5 ☐ Other (Specify	) All C		y Cremati		-	ykesvi1		
Ba	Depar Depar Impor eny in		21. Signature of Funeral Service Licen  Parapalaight	Herbert	P 22	. Name and Address	s of FacilityHa: 95 Sykes	ight Fune sville, M	eral Hom ID 21784	е &	Chape1
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death. Done cause on each line.	o not ent	er the mode of dying	, such as cardia	c or respiratory arr	est,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	· Metastat	n's	Colon	Cance	. h			Onset and Death
	/Medical Examiner		resulting in death)								
1	LXummer	_	Sequentially list conditions,								
	Sit A d	nine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons ∗ueno	28 (1)						
	and al-trai	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence	ce of):					_	
8760,	ficate be executed physician end stransit is the burial-transit	dical E		d.							
89	tificat ng phy as th	ledi									-12-3/11/2
ŏ	th cer tendir r use	an/h	230. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea		Ectopic pregnancy			23d. Dat Mor	e of delive	ery Day Year
C.	thet the death certificed by the attending of detached for use as	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	5 🗆	Other (specify)			14101	III)	Day Toal
<u>ď</u>	thet the	Ph.	Part II. Other significant conditions or	ontributing to death but not resulting	a in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use contr	ribute to t	he cause of death?
Division of Vital Records, P.O. Box	quires in signe	Completed by Physician/Me	No					1 🗆 Y	es 2 No	3 Prot	oably 4 Unknown
O O	aw requir is been si 2 should	plet						24a. Was a	an 24b. V	Nere auto	ppsy findings available impletion of cause of
ř	hysician: The law his certificete has t I director, page 2 s	E						perfor	med?/	death?	
<u>ta</u>	ian: rtifice stor. p	Bec	25. Was case referred to medical				26. Place of De	ath (Check only or	<u>'</u>		
<u>&gt;</u>	Physic this ce al direc	P.	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatien		4 Li Nui sing i	dome 5 ☐ Resid	ence 6 26th	er (Specif	M Inpatient
ב	ing P Wher t	ë	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28t	o. Time of Injury	Work	?``	28d. Describe h	ow injury occurr	ed	1,0-1
<u>s</u>	tendi Jeath tor: / the fi	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				′es 2 □ No	201 1		D	at Basta Number
<u>&gt;</u>	or At Bitter of Direct in by	Certification;	4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	, tarm, str	eet, factory, office		City or Tow		er or mura	al Route Number,
	To the Hospitel or Attending Physician: The law requires that the death certific within 24 hours effecteath.  To the Funaral Director: Affer this certificate has been signed by the attending a completely filled in by the funeral director, page 2 should be detached for use as	edical C	(Check only 2 Medical Exam	ysician: To the best of my knowled iner: On the basis of examination	dge, death and/or in	n occurred at the tim vestigation, in my op	e, date and plac inion, death occ	e, and due to the curred at the time, c	ause(s) and ma	inner as s and due t	stated. o the cause(s)
	thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License	number		29d. Date signed	d (Month.	Day, Year)
	5 7 K 1		0 1	int, m.D.			5552		1/2		
7	1		30. Name and address of person who	1	a) (Tune	Print)					
	5			+2 m.o. 555	8	Centen	Ares	- Wes	tminst	ar, h	nd, 21157
	Sta	ite	31. Date liled (Month, Day, Year)	32 Registrar's Signature							
	Registi	ar	JAN 3 0 20	JU8		enter)					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jay 26 2608 **Physician** ANUARY /Medical <u>Barbara Ann Tress</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Arunde Glen Burnie 4nne Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Months Days Hours Director 283-24-0348 9/29/29 Ohio 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? Funeral 701 Mayo Road 21061 <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ es 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔊 No Specify. þ Year or Dates: 1952-53 Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than ' Elementary/Secondary (0-12) Coflege (1-4or 5+) 12 Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be <u>John P. Sweda</u> <u>Stella Sweda</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Patricia Ziegler 313 Cheddington Rd. Linthicum Heights, Md. 21090 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Loudon Park Cemetery: 1/29/08 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Liter see 3620 Wilkens Ave. Baltimore, Maryland 21229 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one occurs on each line. 23a. Part1. Enter the disease, shock, or Neart failure. Li Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NEUMONA /Medical Due to (or as a consequence of): HEART FAILURE Examiner ESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4⊡Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division or Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform page 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signator and title of certifier leted cause of death (turn 23a) (Type, Print 30 Name and address of person w

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Lois J. Veniev 11:55 AM January 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital 20 Baltimore Baltimore N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 11/9/1923 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 84 219-18-9158 Director MD Usual Residence of Decedent 10a. State 10c. City, Town or Location a or 28a-f show the notified at 10b. County 10d. Inside City Limits MD. Baltimore Director Gwynn Oak 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 items 23a 2112 Tirker L*a*ne Examiner must 21207 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: specify: African American þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Tem 27 is marked other that any injury or other traumatic event, the once. 12th Health Care Provider Rosewood State Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander Isabelle Mabel Todd ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalind V. Alexander / Daughter <u> 27600 Forester Ave., Highland, CA 92346</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/29/2008 Metro Crematory Balto.M.D 21. Signature of Funer Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 <u>Liberty Rd.</u>, Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration preumoni /Medical Due to (or as a consequence of): **Examiner** Due to (or as a conseque to of): Sequentially list conditions, if any, leading to immunicate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed the burial-transi colorectal cancer Metastatic Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by constipation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

as been signed 2 should be det page certificate funeral director, Be this Certification: To After

Jessing

Breast cancer

24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼ No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

29a. Certifier (Check only one)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

, M.D

RES 000 January 26, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARKOS KASHIOURIS, MD SINAI HOSPITAL OF BALTIMORE, 2401 W BELVEDERE AVE, BALTIMORE, MD 2121S 31. Date filed (Month, Day, Year)

State Registrar

Medical



DHMH 17 Rev 1/2001

or Attending Physician:

after death filled in by the

within 24 hours a To the Funeral I

completely

			For State Registrar	State of Maryland /	Department of Health and Certificate of Death	Mental Hygier	2000	02296
3	Physici /Medic		1. Decedent's Name (First, Middle, Last)		ker	2. Date of Death Month	24, 2004	3. Time of Death 3. 00 PM
	Examir		4a. Facility Name (If not institution, give to 193) Lincoln A	We	4b. City, Town, or Location of Dea Halethorpe intravi If Under 1 Year   If Under 24 Hi	Ų-	4c. County of Dea	th thplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sept 239-48-8780 1	M 2□ F 7. Age (In yrs. last b	Yrs. Months Days Hours Mi		1939 Nº	COPOLINA
	Maryland	tor	10a. State 10b. County  MD Ba Himor	e Halet	wn or Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the 23a or 28a at be not	Funeral Director	10e. Street and Number		10f. Zip Code 2)337	10g. US	Citizen of What Co	ountry?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene.  If Item 27 is marked other then "natural", or Items 23a or 28s-f show or other traumatic event, Ite Medical Examinar must be rectilised at	þ	1 1 10 10 11 1	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify:	(Specify Yes or No- into Rican, etc.)	14. Race - Ame Black, Whit Specify: Bl	
21215-0036	d within 72 hogiene. or then "natu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking 16b	Kind of Business	/Industry
Maryland	should be filed nd Mental Hygi s marked other umatic event, II	To Be (	17. Father's Name (First, Middle, Last) Henry Whitake		Viola	ame (First, Middle, Maid Archer		
	1 and 2 sho Health and Ism 27 is mu		19a. Inform nt's Name/Relationship (Ty Gwendolyn Whitak	lea-wife 19	b. Mailing Address (Street and Number or	alethorpe, 1	mo 212	227
Baltimore,	Pa men ury		20a. Method of Disposition  1. Burial 2 □ Cremation 3 □ F  4 □ Donation 9 □ Other (Specify)	Removal from State  Arbut	of Disposition (Name of ery, crematory or other place) US Mem. Park 2-	2-08 AT	Location - City or	mp.
Ball	permit. Pag Department Important: I eny injury o		21. Signature of 5 neral Service License	gret	22 Name and Andress of Facility (1707)	Pass Bal	to ms	21229
28	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	ications that caused the death. Do ne cause on each line.	o not enter the mode of dying, such as card			Approximate Interval Between Onset and Death  Months
	/Medical Examiner	_	resulting in death)  Sequentially list conditions,	Due to (or as a consequence				
,092	death certificate be executed e attending physician and of for use as the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence  Due to (or as a consequence				
89	leath certificate be attending physic	Medical	IF FEMALE:	d				
P.O. Box	that the death or led by the attend detached for us	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetaf deat  4 ☐ Pregnant at time of death  9 ☐ Unknown	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of de Month	livery Day Year
	w requires that been signed t should be det	by	Part II. Other significant conditions con	ntributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobace	N.4	o the cause of death? robably 4 □Unknown
Records,	a 2.5	Completed				24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
Vital	ysician: The l is certificate ha director, page	Be	25. Was case referred to medical examiner?	1		eath (Check only one)		
of	ding Ph h. After th funeral	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	All Inpatient 2 ER/C 28a. Date of Injury (Month, Day Year) 28b.	Outpatient   3   DOA   Other: 4   Nursing	Home 5 X Residence 28d. Describe how i	e 6 ⊡Other (Spe	ecify)
Division	# # ± =	Certification:	3 Suicide 6 Could not be determined	28e. Pface of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or F tate)	lural Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edical (	29a. Certifier Centifying Phy (Check only one)	sician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death occurred at the time, date and pla and/or investigation, in my opinion, death oc	ice, and due to the caus curred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	le un	29c. License number		Date signed (Mon	
1 /	5		30. Name and address of person who co		D1635 (Type, Print) CATON AVE	7	124/2	2008
10	/ Sta	ato.		AGNES 900 Registrar's Signature	CATON AVE I	SALTIMORI	5 MD	21229
ار (کام	Regist		31. Date filed (Month, Day 3 ear) 20	00	S. J.			

State of Maryland / Department of Health and Mental Hygiene) State Registrar Amend #5, perFH, g876, 2/28/08 TT Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2008 27. 5:10 a<sup>™</sup>. HELLMERS WINTER Jan. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore College Manor Lutherville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. August 25, 1908 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1□M 2□F <del>215</del>-05-9082 Maryland 99 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f ehow 1 □ Yes 2 □ No Director Maryland Baltimore Lutherville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code itama 23a or 300 West Seminary Avenue 21093 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2AONo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or itea ury or other treumatic event, the Medical Exert rea 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: White 3XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christian Hellmers Margaret Kister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Heisler Guardian 102 West Pennsylvania Avenue Suite 200 Towson MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
XXBurial 2 Cremation 3 Removal from State 20c. Location - City or Town, State permit. Pages 1 Important: If it any injury or o once. Parkwood Cemetery Feb 2, 2008 Baltimore Maryland 4 □ Donation 5 □ Other (Specify) ignature of Funeral S orice License 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gastrointestinal Hemorrhage **Physician** day /Medical Examiner -hronic Lear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the phys as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an pertension has autopsy performed? this certificate har ral director, page 2 1 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1-55 is cal 1 Yes 2 No Certification; To 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 DNatural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ro the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7444 MUD 30. Name and ad ress of person who compfeted cause of death (Item 23a) (Type, Print) 6 Towson. MID Alexander hen 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year /Medical 2000 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner und 9. Birthplace Country) 7/Age (In yrs. last birthday If Under 1 Year Date of Birth (Month, Day, Year) **Funeral** or Foreign Days Min. Hours 213-36-4739 1 XM 2 ☐ F Yrs. 69 Director 04/10/1938 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at Director 1X Yes 2 □ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4821 Hazelwood Avenue "natural", or items 23a o 21206 U.S.A. Funeral within 72 hours after death Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event 皇 12 Salesman Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Joseph Winterling Rose Gillen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patsy Winterling - Wife 4821 Hazelwood Avenue, Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XI Burial 2 □ Cremation 3 □ Removal from State ☐Donation 5 ☐ Other (Specify) Holly Hill Mem Garden 01/31/2008 Middle River, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. ature of Fun ral Service D 407 Old Eastern Avenue, Essex, Maryland 21221 s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Enter the disease, or complication, or heart failure. List only one car 23a. Approximate Interval Between Onset and Death Imme ate Cause (Final diseas) or condition resulting in death) **Physician** ALATO MYOCONAIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the death certificate be executed Box 68760, CS burial-tra Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) P.O. ed by the a 1 Tes 2 □ No 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ sign 1 🗌 Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1□ Yes 2 **X**No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 □ No death. 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the Funeral Director: After this certific completely filled in by the funeral director, To the Hospital or Attending within 24 hours a To the Funeral I

State

29b. Signature and title of certifie

Day, Year)

3 0

Registrar

DHMH 17 Rev 1/2001

29d, Date signed (Month, Day, Year)

and manner stated

arch

Régistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8-00553 evin Dale Warr	on	Please Type or Print in Black Indelible Ink. Ensure All Copie		ible.						
eviii Dale wali		Jr. State of Maryland / Department of Health and Mental Hy  1- For State Certificate of Death		200	B 02299					
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death					
Medical Exami		Kevin Dale Warren, Jr.	Month January 19	Day Year ), 2008	2325 hrs					
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death						
	М,	Harbor Hospital Baltimore	Jan. 18:11	N/A	-1 (01-1					
Funeral Director		010 /1 /COC 1/2 Months Days Hours Min.		(MM/DD/YYYY) 9. Birt Foreig	n Maryland					
Director	-	Usual Residence of Decedent	12/02/	1993   Col						
any	ŀ	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
<u> </u>	٦	Maryland N/A Baltimore			1 X Yes 2 No					
daryland 28a-f show d at once	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	itry?					
1 (4 S O after death with the Maryland al", or items 23a or 28a-f sho		3704 - 10th Street 21225		U.S.A.						
	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 X Never Married 2 Married Forces?  Armed Forces?  If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	can Indian, Black,					
er des		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: Bla	ack					
urs af	g g	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired to the complete of the compl		16b. Kind of Business/I	ndustry					
6 72 hc	lete	School	,							
5-0036 led within 72 hours after death itygiene, other than "natural", or itee the Madrial Examiner must	Completed by		L							
21215-0036 July be filed within 7 Mental Hygiene. marked other than ic event, the M dira	17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Surname)									
2121: wld be fil Mental I marked	일	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or R			, Zip Code)					
MD and 2 shoulth and 27 is aumatic		Alice Almoghrabi / Mother 1903 McHenry Street		more, Maryl						
		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or						
Page nent o		4 Donation 5 Other Specify: Holy Cross Cemetery 01/2	28/2008		e, Maryland					
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr				eral Servic						
Physician	4001 Kitchie Highway Baltimore, Hai									
> /Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Bronchopneumonia			Between Onset and Death					
xaminer		or condition resulting in death)  Due to (or as a consequence of):								
	ايا	Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of):								
	in in	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated								
ed Isi	Examiner	events resulting in death) Last Due to (or as a consequence of):								
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c 68760, certificate be e ending physicia	<b>Nedi</b>	X UNPENDED #23a, 27, perME, C876, 2/25/08 TT  IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	,					
587( ertifica ling pl	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregna	ncy		Day Year					
Box (e death ce the attence ed for use	sici	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown 9 Unknown		1						
CO. BO. that the deat ned by the at detached for	F.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?					
cords, P.O. law requires that the has been signed by	d by		1 Yes	2 No 3 Prob	pably 4 Unknown					
rds requi	Completed by		24a. Was a		topsy findings available completion of cause of					
tal Reco tian: The law certificate has	Ĕ		perfor	med? death?	es 2 No					
Vital Rec ysician: The this certificate director, page	Be C	25. Was case referred to medical 26.Place of Death (Check of D	only one)		[]					
of Vital Records, ng Physician: The law requir Wher this certificate has been some and director, page 2 should!	입	1 V Yes 2 No		Residence 6 Other	:					
n of V ding Phy. After th funeral		27. Manner of Death 28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No	28d. Describe h	now injury occurred						
ivision or Attene after death Directors in by the	cati	Accident Investigation Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f Location (S	Street and Number or Ru	ral Route Number City					
Division pital or Attendio ours after death, ceral Director: A	Certification:	Suicide 6 Could not be determined (Specify)	or Town, S		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
Hospil 24 hou Funcr		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the cause	e(s) and manner as state	ed.					
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funcral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for ur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	t the time, date a	and place, and due to th	e cause(s)					
FSFS	ž	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo						
		Jaina Jeel MD O.C.M.E.		January 20, 2008	3					
CT		30. Name and address of person who completed cause of death (Item 23a)  Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201							
W St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature								
Regist	_	JAN 3 0 2008 5 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2								

08-00553

			State of Maryland / Department    State of Maryland / Department    Corr	artment of Health and Mertificate of Death		211112	02300
		-7	Registrar  1. Decedent's Name (First, Middle, Last)		2. Date of Death	. No/ U U U	3. Time of Death
	Physici /Medio		Virginia Elizabet	h Wheeler	Month January	Day Year 2008	9:45 A. <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	<u> </u>	47	Caton Manor  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year   If Under 24 Hrs.	8 Date of Birth	N/A	place (State or Foreign
	Funeral Director		216 78 7817 1 M 2 Tx F 86 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yo 02/25/19	ear) Coul	rginia
	pu »		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lor				
	Maryla f shoved at	ō	Maryland Anne Arundel Baltimo				10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	r 28a- notifi	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Cou	ntry?
	th with		5717 Gischel Street	21225		U.S.A.	
	er dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spec f Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
35	be filed within 72 hours after death with the Maryland ital Hyglene.  d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Year or Dates:	1 ☐ Yes 2 🕱 No <i>Specify:</i>		Specify: Wh:	ite
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7	vithin ne. han "	mple	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working OO NOT use retired) emaker	9	Own 1	Jomo
ק ס	filed v Hygie other i	ပ္ပ	12th Home	18. Mother's Name	(First, Middle, Mai		Tome
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Mary	2 sho			g Address (Street and Number or Rural			
	s 1 and if Health item 27 other to					e, Marylar c. Location - City or T	
D D	Pages nent of int: If its iry or o		1 Burial 2 Tyleremation 3 Removal from State 4 Donation 5 Other (Specify)  Bayview C	natory or other place)	/0000	altimore,	
Baitimore,	permit. Pages Department of Important: If i any injury or o					al Service	
מ	e i i i			001 Ritchie Highway	Baltim	ore, Mary	land 21225
			23a. Part1. Enter the disease, or complications that cause (the death. Do not enter shock, or heart failure. List only one cause on each limit	er the mode of dying, such as cardiac or	respiratory arrest	,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Congusture	Har ala			/ Week
	Examiner		Due to (or s a contequence of):	manie			2 100 . 06
	<b>D</b> .=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0 2-			Z Michael
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):	Keckeyn			5 mass
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7.	requires that the een signed by th hould be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
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	sician: The law certificate has t irector, page 2 s	-	GT West of the state of the sta				2 🗆 No
5	/sicial	o Be	25. Was case referred to medical examiner?  1 ☐ Yes ♣ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death		e 6 Other (Spec	(5.)
5	ng Phy fter thi	-	27. Manner of Death 28a. Date of Injury 28b. Time of		Bd. Describe how		
202	tendir eath. tor: Al the fu	catio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
2 2 2	lor At after d Direc	Certification:	4 ☐ Homicide determined 28e. Place of injury - At home, farm, streen building, etc. (Specify)	et, factory, office 28	3f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
	ospita hours nneral y filled		29a. Certifier Certifying Physician: To the best of my knowledge, death				
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invane) and manner stated.				
	vitl To	2	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print)		127/0	<del> </del>
2			MIGE HOMAN NO = 271) Han	D 25044  Print)  nman do Fenc Ra	1 21.	22)	
Q.	Sta	_	31. Date filed (Month, Day, Year)  JAN 3 0 2008  32 Registrar's Signature	and I			
	Registr	ar	JAN O V LOOD				

#### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician JANUARY 25 ANNA WEINBERG /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RUXTON OF PIKESVILLE HEALTH CTR. PIKESVILLE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 01/10/1915 **Funeral** Days 1 □ M 2 X F 93 213-01-6547 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location BALTIMORE MD BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 7 SUDBROOK LANE 21208 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KRAMER DAVID SADIE ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 3000 STONE CLIFF DR., #303, BALTIMORE, MD LARRY WEINBERG / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State SHAAREI ZION CONG 01/27/2008 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final THEROSCENOTIC CANDIONASCUCIO **Physician** /Medical Examiner

and manner stated.

law requires that the death certificate be exe Division or Vital Records, P.O. Box 68760 attending | To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica

	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not enter the mode of dying, such as cardia one cause on each line.	c or respiratory arrest,	Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	a. ATHEROSCENOTU CANDIOU  Due to (y as a consequence of):	Ascuch	DISEASE and Death
niner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):		/
dical Exar	that initiated events resulting in death) Last	C. Due to (or as a consequence of):		
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown		23d. Date of delivery Month Day Year
ed by Pl		ontributing to death but not resulting in the underlying cause given in Part I.  A ENIAC FAICN RE	The state of the s	o use contribute to the cause of death?  2 No 3 Probably 4 Oriknown
Complete	ALZHEIM	ENS DEMENTIA	24a. Was an autopsy performed 1 Yes 2 \( \bar{\Delta} \)	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
Be	25. Was case referred to medical examiner?		ath (Check only one)	
၉	1 ☐ Yes 2☐ <b>N</b> No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA Other: 4 X Nursing H	Home 5 ☐ Residence	6 ☐Other (Specify)
ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how in	jury occurred
cal Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
ical (	29a. Certifier (Check only 2 Medical Exam	ysician: To the best of my knowledge, death occurred at the time, date and place niner: On the basis of examination and/or investigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	e(s) and manner as stated.  and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2008

14. Race - American Indian,

OWN HOME

ST00P

ROSEDALE, MD

WHITE

Black, White, etc.

4c. County of Death

BALTIMORE

USA

6:05 A M

9. Birthplace (State or Foreign

ÄÜSTRIA

10d. Inside City Limits

1 ☐ Yes 2 X No

21209

MD 21208

State

29b. Signati

eand title of certifier

30. Name and address of person who complete

JAN 3

Year)

0

31. Date filed (Month, Day,

death (Item 23a) (Type, Print

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JAN 3

0

9

32 Registrar's Signature

				For State Ragistrar		State	of Maryla		•	ent of F ate of			ental Hy	giene Reg. No.	008	0.2	303
				nagistrar     Decedent's Name	e (First, Middle	, Last)							2. Date of De	ath		3. Tin	ne of Death
		Physici		Ber		811	706	-0 L1	t	Bal	ldu	nin	Month	Day	200 S	1/2	40 AM
		/Medic Examin		4a. Facility Name (I		aive street and nu	ımber)	20100	4b. C	City, Town, o	or Location	of Death		4c. (	County of Deat		,
V		Examin	er			Memoria		nita		avre o					Harfo	m	
		Funeral		5. Social Security N		6. Sex		rs. last birth	fay) If Un	der 1 Year	If Under		8. Date of Bir	th	9. Birtl	hplace (St	ate or Foreign
		Director		224-46-	0397	1 □ M <b>20X</b> F	72	Yr	s. Mont	hs Days	Hours	Min.	8. Date of Bir (Month, Da 8/15/1	936	Vir	ğînia	l
	-	o		Usual Residence of													
	-	show	_	10a. State	10b. County		10c.	City, Town o									le City Limits
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	4	or 26	Oire	10e. Street and Nur						Zip Code				_	en of What Co	untry?	
	-	deeth with the Mary ms 23e or 28e-f sh r mast be notified	la	1745 Br	yan Rd.	•				21078					.S.A.		
		items	Ine	11. Marital Status		12. Was Dec Armed F	edent Ever in orces?	n U.S.	13. Was De If Yes,	specify Cub	Hispanic Or an, Mexica	rigin? (Spe in, Puerto f	cify Yes or No Rican, etc.)	- 1	<ol> <li>Race - Ame Black, White</li> </ol>		n,
	36	ori	by Funeral Director	1 ☐ Never Marr 3 ☐ Widowed		If Yes, G	2 MNo ive		1 ☐ Ye	s 2K No	Specify.	:			Specify: Wh	ite	
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	21215-0036	illed within 72 hours after deeth with the Maryland Hygiene. Iffise then "naturs!", or items 23e or 28e-1 show ant, the Medical Exactor must be notified at	Completed	Elementary/Seco	ondary (0-12)	College	(1-4or 5+)	Sal	es-Cl	erk				Cant	teen		
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	ary.	and M is mar	-	19a. Informant's Na	ame/Relations	nip (Type, Print)		19b. N	lailing Addr	ress (Street	and Numb	er or Rura	l Route Numb	er, City or	Town, State, Z	(ip Code)	
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		กงร์เต่ลก		Approximate Approximate Intervite disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a. Cauge / hre heart failure.													
		/Medical		resulting in death)	on .	a	(or as a cons		hv.	e i	100	n		m	•		
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	200	to the Propriet of Attending Frighting within 24 hours effected. To the Funeral Director: After this certific completely filled in by the funeral director.	Medicai	29a. Certifier (Check only one)		g Physician: To th Examiner: On the l											ıse(s)
	į	ithin (	Med	29b. Signature and	title of certifier		illor stated.			29c. Licens	se number			29d. Date	e signed (Monti	h, Dey, Ye	ar)
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				30. Name and addr	Jaco de naciona	who completed cau	se of death (	/ / L)	me Print)	~		100	l	01	125/	20	100
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	ž	Registra			JAN 3 (	2008	3450	fil 1	A STATE OF THE STA	6:50							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Nancy Lee January /Medical Burcker 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 11824 Paden Ave. Smithsburg If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕅 F Director 220-40-0742 64 April 15,1943 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State "natural", or Items 23a or 28a-f show dical Examiner must be notified at Director MD Washington Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11824 Paden Ave. 21783 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed er than "natur the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the M Bus Driver Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theodore R. Fritz ဥ Jeannette Mumma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannette M. Thompson/Daughter 1162 Outer Drive, Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important; If Ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

Cedar Lawn Mem. Park 1/25/2008 | Hagerstown, MD 21. Signature of Funeral Service Licensee

S. Mark Sun 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

**Physician** /Medical Examiner

physician s the burial

as attending j

nse

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Medical Certification:

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division or Vital Records,

P.O. Box 68760,

only one cause on each line.	Interval Between Onset and Death
a COFUNARY AFTERY DISEASE	Griser and Death
Due to (or as a consequence of):	
D. INSULIN DEFENDENT DIABETES	
Due to (or as a consequence of):	
Due to (or as a consequence of):	
23c. If yes, outcome pf pregnancy	23d. Date of delivery

Securities if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine by Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? \_Live birth 2 Fetal death 3 Ectopic pregnancy 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ENDSTAGE FENAL DISEASE Completed MYPEFCHULESTROLLEMIA HYPERTENSION. CHEONIC OBSTRUCTIVE PULMONARY DISEASE Be

23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24a. Was an

Month

performed2

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Day

Year

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No

Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

Day

21,

Year

2008

Washington

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

Pennsylvania

4c. County of Death

U.S.A.

Specify:

14. Race - American Indian,

White

Black, White, etc.

27. Manper of Death 28a. Date of Injury 1 Natural 2 Accident 5 Pending investigation 6 ☐ Could not be 3 ☐ Suicide determined

28b. Time of 28c. Injury at Work? (Month, Day Year)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

4 ☐ Donation 5 ☐ Other (Specify)

Immediate Cause (Final

disease or condition resulting in death)

29c. License number 00062327 29d. Date signed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

68 STRUT F MILL MAGGRETOWN MO 31. Date filed (Month, Day, Year)

State Registrar

5

s after death.

I Director; After this
of in by the funeral d

within 24 hours aft To the Funeral Di completely filled in

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 8:10 PM **Physician** January 21 2008 Heston A. Bradford /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Point VA Maryland rerry tealth Care System If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (Ih yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1**X** M 2□ F FEB 20. Maryland 1926 219-22-3409 81 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 1 ▼Yes 2 No Cochranville Director Chester Pennsylvania 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19330 United States 33 Village Drive Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? World 1 to yes 2 □ No. If tes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify. Baltimore, Maryland 21215-0036 Be Completed by White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fuel Delivery Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cecelia Warrington Reuben Bradford BRADFORD, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 33 Village Drive, Cochranville, PA 19330 David L. Bradford/Son 20b. Place of Disposition (Name of Cherry Hill Methodist Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition January 25, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cherry Hill, MD 2008 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 21. Signature of Funeral Service Licensee Wisten Ikeks ( Mesman Approximate Interval Between Onset and Death 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Fibrillation Immediate Cause (Final disease or condition resulting in death) Atrial LIKNOWI **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death Month in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown 1)ementia Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performe 2 No 2 No 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Injury 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

140

KAR E

Medical

(Check only one)

29b. Signature and title of certifier

Deborah 31. Date filed (Month

completed cause of death (Item 23a) (Type, Print)

m.b. VA

29c. License number Fransylvania MD 072692L

VA Maryland Health Care System Perry Toint, Maryland

29d. Date signed (Month, Day, Year)

January 21, 2008

			Please Type or Pri									000	00
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			Hegistrar  1. Decedent's Name (First, Middle, Last)		001	incate o	ח וו	Calli	2. Date of D			3. Time of	Death
	Physici /Medio		Ralph Kenne	th Brand	don				Januar	у	23 2008	0720	АМ
	Examin		4a. Facility Name (If not institution, give street and number	)				ocation of Death	1	4	c. County of Death	1	
	Funeral		131 Club Lane 5. Social Security Number 6. Sex 7. A	ge (In yrs. last t	birthday)	Ear1	irth	Ceci1	place (State o	r Foreign			
	Director			87	Yrs.	Months Day	ys	Hours Min.	April 1	Day, Yea	r) Col	intry) nessee	
	land ow		Usual Residence of Decedent           10a. State         10b. County	10c. City, To	wn or Lo	cation						10d. Inside Ci	ty Limits
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	or 28	Director	10e. Street and Number			10f. Zip Code					citizen of What Co	•	
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Ma	th and 2 sl	1	19a. Informant's Name/Relationship (Type, Print)  Ethel G. Brandon/Wife					Earlevi			or Town, State, Z Q1Q	p Code)	
J.	of Heal	1	20a. Method of Disposition	20b. Place	Location - City or 1	own, State							
Baltimore,	Page ment a		1 🏻 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specity)	St. S Cemet	rleville	, MD							
Bail	permit. Pages 1 end 2. Depertment of Health ar important: If item 27 ie eny injury or other treu		21. Signature of Funeral Service Licensee		Hi	. Name and Add .CKS HOI	ldress Ne	for Fune	erals,_	P.A.			
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	To the Hospital or Attending Physician: The law requires thet the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate hes been signed by the attending physicist completely filled in by the funeral director, page 2 should be detached for use as the bu	ledicai	29a. Certifier (Check only one)  Certifying Physician: To the bess 2 Medical Examiner: On the basis and manners	of examination a	ge, death and/or inv	occurred at the estigation, in m	e time ny opir	, date and place, nion, death occur	and due to the rred at the time	e cause e, date a	s) and manner as nd place, and due	stated. to the cause(s	)
	To the within To the compli	Me	29b. Signature and title of certifier	^	\	29c. Lice		_			ate signed (Month		
			* Robert a Monteler	ne M	ر ر	Do	os	3675		1	123/08		
	341		30. Name and address of person who completed cause of Robert A. Monteleone, 1	death (Item 23a	(Type,	Print) High	1 5	A. Suis	214 6	=  K+	on MO	21921	
	Sta	te	31. Date filed (Month, Day, Year) 3 Regist	trar's Signature	1	al a		0,7€			,,,,		
	Registr		JAN 3 0 2008 S	trar's Signature	A STATE OF THE PARTY OF THE PAR	sti)							

#### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Barrineau 13 2008 Kaylin January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Randallstown Hospital Center Northwest Baltimore County If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. (Month, Day, Year) 5. Social Security Number Sex. 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🔀 F Yrs. 38 8-28-1969 Director 221-58-5698 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygene. Important: If them 23s or 28a-f show any jour teems 23s or 28a-f show any jourly or other traumatic event, the Medical Examiner must be notified at any journor or other traumatic event, the Medical Examiner must be notified at Director Baltimore County Windsor-Mill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 9 Balsett Ct. by Funeral USA 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: black 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry Boys/Girls 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Club counselor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence Tilden Deborah (Harrington) Henry ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NewCastle, DE 19720 Deborah Henry Beacom Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Chestertwp, PA Haven Crematory 1-19-08 4 ☐ Donation 5 ☐ Other (Specify) Phone Holdse of Filly Wright Mortuary 21. Signature of Funeral Ser 208 E. 35th Street Wilm., DE 19802 23a. Part1. Enter the disease, or complicitions that caused to deat 1. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art failure. List only one cause on each line. Immediate Cause (Final disease or condition Hyperkalemia que to (or as a consequence of): **Physician** resulting in death) /Medical Examiner failure Acute renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed Non Steroidal anti inflammatory analgesic use and as the burial-trai Due to (or as a consequence of): ned by the attending physician detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No 5 Other (specify) 9□ Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ should be cardiomyopath 2 No 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No has autopsy performed? res 2 No Bicytopenia 25. Was case referred to medical examiner? Hyponatremia To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) 2 No 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Manuer of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director; 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 🛣 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Year

11:55 PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

Wilm., DE

Day

29d. Date signed (Month, Day, Year)

Januar

3 Probably 4 □Unknown

2008

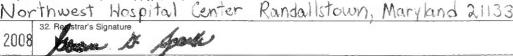
State Registra

31. Date filed (Month, Day, Year) **JAN 17** 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Boston



DHMH 17 Rev 1/2001

29c. License number

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 2008 12, 7:10 Mary Elizabeth Brashear January /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CitizensRehabilitation & Nursing Home Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🛣 F Yrs. July 12, Director 219-80-8680 82 1925 Maryland Usual Residence of Decedent Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28e-f show 27 is marked other then "natural", or itams 23s or 28s-f shot treumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Carroll Mt. Airy the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "matural", or Itams 23a any injury or other treumatic event, the Martines 2000. 21771 USA 2110 Flag Marsh Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rhoda Ellen Stull Aubrey Austin Fritz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21771 2110 Flag Marsh Road, Mt. Airy, Maryland Doris E. Johnson, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Pleasant Hill Cemetery 1/16/2008 Monrovia, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Molesworth-William Funeral Home 21. Signature of Funeral Service License an M. Jersen 26401 Ridge Road, Damascus. Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mos. Ischemic Left Leg with Sepsis /Medical Due to (or as a consequence of): Examiner Advanced Perpheral Vascular Disease Yes. Sequentially liet for citics if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Dementia/Vascular Yrs. and Due to (or as a consequence of) Box 68760. physician Physician/Medical Hypertension with Atrial Fibrilation Yrs. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ğ in the past 12 months? 1 ☐ Yes 2 🗓 No 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records. 8 icate has been sig page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hypothyroidism, Chronic Kidney Disease Stage III, Be Completed Diabetes Type II, Chronic Obstruction Pulmonary Dise Depression, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an <u>Disease</u>, autopsy performed 2 No certificate 1 ☐ Yes 2 No Cerebral Vascular Accident, Ostevarthritis, Castric Reflux Division of Vital Attending Physicien: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 2 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 X Natural 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funerel Director: Aft completely filled in by the fun 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifie 1KC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 14, 2008 D54749 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 801 Toll House Avenue, D-1, Frederick, Maryland J. Allen Reilly, MD, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)

JAN 1 5 2008

DHMH 17 Rev 1/2001

32. Registrar's Signature

Educa

			1 = For State Registrar		Maryland	d / Depa <i>Cei</i>	artment rtificate	of H	ealth a Death	and M		giene leg. No.	008	023	310
ı	Physici /Medic		Decedent's Name (First, Middle Barry	, Last) David		Barros					2. Date of Dea Month January !	Day	3 Year	3. Time o	f Death M
	Examin		4a. Facility Name (If not institution, 8201 Fort Foote Ro	•	iber)				Location o	f Death		1	ounty of Dea		
	Funeral Director				7. Age (In yrs. la		If Under		If Under 2 Hours	24 Hrs. Min.	8. Date of Birth Month, Day July 27,			thplace (State	or Foreign
	rland ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside C	ity Limits
	8a-f eh	ector	Maryland Prince (	George	Fort	Washing									2 X No
	h with th	al Dire	10e. Street and Number 8201 Fort Foote Road	1			10f. Zip	207	44				n ol Whai Co USA	ountry?	
9	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther than "natural", or items 23a or 28a-f ehow event, I're Medical Examinar must be notified at	y Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Marri	Armed For	dent Ever in U.S ces? 2 (A) No	1	Was Decedif Yes, special		spanic Origin, Mexican	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		Btack, Whit		
-00	2 hours leatural,	ted by	3 Widowed 4 Divorced  15. Decedent	Year or Da	tes:	16a. Deced	ient's Usua	I Occupa	tion				of Business		
21212	d within 7 glene. er than "n if e Mad	Completed	(Specify only highes Elementary/Secondary (0-12) 12	t grade completed) College (1-	4or 5+)	(Give life. ( Mainte	kind of wor DO NOT us ENANCE	k done di e retired)	uring most	of workin		Privat	te Indo	ustry	
Baltimore, Maryland 21215-0036		To Be (	17. Father's Name (First, Middle, L Luciano Monahan B								(First, Middle, quendo Pa		mame)		
Mar		0.5	19a. Informant's Name/Relationsh Victoria Barros/Mot				-				Route Number	-		Zip Code)	
nore,	ages 1 and 2 nt of Health t: If Item 27 I		20a. Method of Disposition 1   Burial 2 □ Cremation	3 □Removal from S		ace of Dispo metery, cren ngton N	sition (Nam natory or oti	e of her place	)	Da	ate	20c. Locai	tion - City or		
Baitil	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		4 Donation 5 Other (Sp. 21. Signature of Funeral Service L		NIII	22	. Name and	d Address	s of Facility		ge P. Kal Hill, Md.	as Fun		me	
ı			23a. Part1. Enter the disease, or shock, or heart failure. List of	omplications that ca only one cause on ea	used the death.									Approxima Interval Bei	ween
	Physician /Medical	1	Immediate Cause (Final disease or condition resulting in death)  a. Acute Myocardial Infarction  Due to (or as a consequence of):											Onset and	Death
	Examiner	_	Sequentially list conditions,	b. Atheros		Cardio	vascula	r Dis	sease						
	and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с											
8/60,	cate be ex physicien the buria	dical	d												
O. BOX 6	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 🗍 Fetal on the state of t	death 3□	Ectopic pre					230	I. Date of de Month	-	Year
αs, <sub>Γ</sub>	requires thet the een signed by th nould be detache	by P	Part II. Other significant condition End stage renal dis			ting in the ur	nderlying ca	use give	n in Part I.	-		bacco use		the cause of cobably 4	death?
	The taw req	Completed									24a. Was a autops perform	y .	4b. Were au prior to death?	utopsy findings completion of c	available ause ol
	ertificet	Be Co	25. Was case referred to medical examiner?					,	26. Place	of Death	Check only or		1 🗌 Yes	2 🖸 No	
0 0	ling Physi After this c uneral dire	on: To	1 🗹 Yes 2 🗌 No 27. Manner of Death 1 🗹 Natural 5 🗍 Pending	28a. Date of (Month		R/Outpatien 28b. Time of Injury	28	c. injury Work	at ?		ne 5 Reside 8d. Describe ho		Other (Spe	cify)	
INISION	or Attendent liter death Director: in by the	Certification:	2 Accident investigi 3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Ptace of	ol Injury - At hon g, etc. <i>(Specify)</i>	ne, farm, stre	M eet, factory,		es 2 N		81. Location (Si City or Town		lumber or Ru	ural Route Num	nber,
<b>-</b>	io the nospital of Attending Physician: The law within 24 hours after the formal of the formation of the for	edical Ce	29a. Certifier 1 V Certifying (Check unity one)	Physician: To the bases and manner	sis of examination	ledge, death on and/or inv	occurred a	it the time	e, date and inion, death	l place, ai	nd due to the c	ause(s) an ate and pla	d manner as	s stated. to the cause(s	5)
	within Comple	Me	29b. Signature and title of certifier	and mann	si stateo.			License	_	1.0	2	9d. Date s	igned (Mont	h, Day, Year)	U &
	(2)		30. Name and address of person w				Print)		551.	-111		Jan	J.	11,20	
	Sta	е	Richard Palmer, M.D 31. Date filed (Month, Day Year) JAN 15 2008	4 00 0			e 310 l	Washi	ngton,	DC 20	0032				
	Registra	ar	JAN 1 5 ZUUB	Bleeve X	gistrar's Signati										

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Sanuary **GWENDOLYN** BRITT 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death DOCTOR'S HOSPITAL LANHAM PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Hours 1 □ M 25 □ F Yrs. 579-56-1197 NOV 29 1941 WASHINGTON, DC 66 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ♥ Yes 2 No MD PRINCE GEORGE'S LANDOVER HILLS 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3907 74th AVENUE 20784 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 汉 No Specify. Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STATE SENATOR GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FREDERIC C. GREENE AUDREY BROOKS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3907 74th AVENUE LANDOVER HILLS, MARYLAND 20784 be of Disposition (Name of Date 20c. Location - City or Town, State TRAVIS O. BRITT SR. /HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State HARMONY CEMETERY 1/18/2008 4 ☐ Donation 5 ☐ Other (Specify) LANDOVER, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sever Sever Hyposycemia Due to (or as a consequence of): 3 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 🗆 Yes 2₩ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 | Inpatient 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year)

Physician /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

ms 23a or?

of Health and Mental Hygiene. item 27 is marked other than "natural", or items of other traumatic event, the Medical Examiner mu

permit. Pages 1 an Department of Heal Important: If item 2 any injury or other

Baltimore,

Director

Funeral

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Completed

Be

2

with the Maryland

burial-tran attending pl page 2 s certificate

Physician/Medical

2

Be Completed

Certification: To

Medical

that the death certificate be executed

or Attending

124 hours after death.

Pe Funeral Director: A pletely filled in by the fu

Division or Vital Records, P.O. Box 68760,

director, this

4 ☐ Homicide

29a. Certifier

5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide

determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D43690

11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOUSTAFA SHAMMA, DOCTORS Comm Hosp, 8118 GOOD Luck Rd, Lanham, MD

State Registrar 31. Date filed (Month, Day, Year) 2008 32. Registrar's Signature

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #18, perFH, C876, 2/6/08 TT Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last)  $6^{\text{ay}}$  2008 **Physician** 1:32 A M January George Ε. Barber /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Heartland Health Care Hvattsville 8. Date of Birth (Month, Day, Ye Nov. 5, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, **Funeral** Hours Days 1 ☑ M 2 ☐ F DC579-56-2392 Director 65 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notified at 1⊠Yes 2 No Director Washington DC. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20010 USA 1464 Newton Street, NW Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☆Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nr any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) G Street Fabrics Interior Designer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James W. Barber, Sr. Mary Marbury Edna Vanderhost 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Washington, DC 3900 16th St NW #621 Jovce Gantt/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State |Metropolitan Crematory 1/12/08 4 □ Donation 5 □ Other (Specify) Alexandria, Va 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street, NW Washington, DC 20011 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial-tra Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 ☐ Other (specify) 4□Pregnant at time of death the detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed? certificate 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☒ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and d e to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

Hospital or Attending within 24 hours a pompletely

B

29b. Signature and title of certifier

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7325A Homeover (LECTEBELT MARYLAND 20770 LCTOR MYEINHA 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Medical

JAN 1 6 ZUUS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** KATHERINE **BROWN** М JANUARY 2008 11 2:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CLINTON PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Min. | MARCH | 12 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Year 1 □ M 2 🖵 F Yrs. 81 579-36-4346 1926 VIRGINIA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Tyes 2 □ No Director MD PRINCE GEORGE'S SUITLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20746 USA 2234 SHADY SIDE AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. BLACK Specify: Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental LUCY IRVING RUBEN HILL of Health and Menta Item 27 Is marked r other traumatic ev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3032 TYE RIVER ROAD AMHERST, VIRGINIA 24521 LUCY HARGROVE-HUDSON/DGT 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If Ite any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State HILLS FAMILY CEMETERY 1/17/2008 | LOVINGSTON, VIRGINIA 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RESPIRATORY Physician FAILURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No the detached 9□Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð page 2 should be BRONCHO GENIC CARCINOMA 4 Unknown 1 Tyes 2 No 3 Probably Completed HYPER TENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ¾☐ No autopsy perform certificate or Attending Physician: 25. Was case referred to medical examiner?
1 17 res 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 1 Inpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 ☐ Homicide filled 24 hours a

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

500 RIC

7503 SURRATTS ROAD, CLINTON, MARYLAND TERRY JOBRIE, MD 31. Date filed (Month, Day, Year) **JAN 16** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

within 2 To the

1 Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D40324

29d. Date signed (Month, Day, Year)

January

11,2008

20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Wanda June Van Blargan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Carroll 1501 Miller Rd. Westminster 8. Date of Birth (Month, Day, Year)
Oct. 10, 1927 Birthplace (State or Foreign Country) f Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 195-22-4820 1 □ M 2 1 F 80 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits show 10a. State 10b. County 10c. City. Town or Location r 28a-f show notified at Maryland 1 Yes 2 No Carroll Director Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 1501 Miller Road 21158 U.S.A. Examiner must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White þ 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker the Own Home Department of Health and Mental Hygie Important: If item 27 Is marked other it any injury or other traumatic event, th once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Pauline Agnus Bendon Andrew Paul Shyrock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Diane Louise Conrad-Daughter 1501 Miller Road, Westminster, MD 21158 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 1/16/2008 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 4739 Baltimore Ave., Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each light. Immediate Cause (Final disease or condition resulting in death) **Physician** VS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine executed and burial-trar Due to (or as a consequence of): Box 68760, physician pe Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) ed by the s detached P.O. 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant, conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 autopsy performe death? 1 ∐ Yes 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)
JAN 1 5 2008

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T <sub>20</sub>			Decedent's Name (First, Middle, Last					2. Date of Deat Month	h	3. Time of Death
	Physicia /Medic			Joseph 3	Justinan	Christi	an,Sr.	JAN	19 200	03 4:45 AM
	Examin	Sec.	4a. Facility Name (If not institution, give ST Agnes Hose			4b. City, Town, or			4c. County of De	eath
on 11.5			5. Social Security Number 6. S		(In yrs. last birthday)	Baltim If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. E	Birthplace (State or Foreign Country) Virgin
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be filed within 72 hours after death with the Maryland	f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	) I	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 21No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, W	hite, etc.
72 hou	natura Jical E		15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	ing i	16b. Kind of Busine	ss/Industry
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Pages			M☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)	Kingshi	matory or other place 11 Cemet	e) ery 2/0			,VirginIslan
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be ex	physician and s the burial-transit		resulting in death) cast	Due to (or as a	consequence of):					
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The law requires that the death certificate be executed	attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1□Live birth 2 4□Pregnant at t 9□Unknown		23d. Date of Month	delivery Day Year			
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nysici	nis cel I direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatien	t 2 ☐ ER/Outpatie		4 Li Nursing Ho	ome 5 Reside	ence 6 □Other (5	Specify)
ing in	une une		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	y 28b. Time o Year) Injury	Worl		28d. Describe ho	ow injury occurred	
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P 20657									Jan, 19	, 2009
	U		30. Name and address of person who MAHMOUD AL	DANDASHI	900 C	laton A	re, Balt	imore,	, MD 21	1229
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 3 0	32. Registra	r's Signature	facili				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** ELIZABETH MAY CAULK Jan 12 2008 6:55 PMM /Medical 4a. Facility Name (If not institution, give street and number)
Genesis HealthCare - The Pines 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Easton Talbot 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** Months 1□ M 2□ 94 Director 219-80-1235 OCT 28,1913 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 X Yes 2 □ No MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 DUTCHMANS LANE 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Elizabeth Caulk Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify: WHITE 3 XWidowed 4 ☐ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation traumatic event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within ealth and Mental Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) 6 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental HERMAN ADAMS SADIE COOK 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If Item 27 Is
any Injury or other trau JOY KINNAMON/GRANDDAUGHTER 29352 CLEARVIEW ROAD, EASTON, MARYLAND 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State SPRING HILL CEMETERY 1/17/2008 EASTON, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ereborascular accident Immediate Cause (Final **Physician** new disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner years Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed throsderost ueas attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specity) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ementia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1□ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: ပို 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 A Natural 2 ☐ Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation Injury M 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 within 24 and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year 8:50 pm Catherine Carter January 9. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Nursing Center St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛛 F Yrs. Director 212-56-0414 92 Maryland 07/24/1915 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medic I Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40279 Wathen Road Funeral 20650 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) merican Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify: 3 XWidowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Alfred Thomas Mary Louise Marshall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is rr any injury or other traum Mary Virginia Brown/Daughter 44851 Buck Redman Road, Callaway, MD ace of Disposition (Name of Date 20c. Location 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Sacred Heart Cemetery 01/16/2008 Bushwood, MD 21. Signature of Funeral Service Hornsee 22. Name and Address of Facility Brinsfield Funeral Horn Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
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1 □ Yes 2⊠ No 24a. Was an performed? 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral D 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 10/2008 D0051738

State Registrar

24435 Mervell Dean Road, Hollywood, MD 20636

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kae T. Aung, M.D.

JAN 14 2008

		,	For State Registrar	State of Ma			rtment of H <i>tificate of L</i>			giene Reg. No. (	2008	02318	
Ē	Physici	an	1. Decedent's Name (First, Middle					2. Date of De Month	ath Dav	Year	3. Time of Death 21:30		
	/Medic	al	Mary Pa	tricia Camma	ck		4b. City, Town, or	Januar	ary 14, 200		IVI		
*	CXdIIIII	ei ·	20450 Hampton F	,			Leonard				St. Mar		
	Funeral Director		5. Social Security Number 219–42–2540	6. Sex 7. Age	5 , ,			If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da March	y, Year)	C	thplace (State or Foreign ountry) orida	
Ī	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Loc	ation					10d. Inside City Limits	
	Maryl	tor	Maryland St. M	Mary's	Lec	ona	rdtown					1 □Yes 2 X No	
	th the or 282 e noti	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What C	ountry?	
	s 23a nust b		20450 Hampton			40.11	2065				USA	arioon la dian	
30	be filed within 72 hours after death with the Maryland that Hyglene.  dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	<ul> <li>11. Marital Status</li> <li>1 □ Never Married XX Married</li> <li>3 □ Widowed 4 □ Divorced</li> </ul>	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 💥 N If Yes, Give Year or Dates:	o U.S.		Vas Decedent of Hi i Yes, specify Cuba □ Yes 2🏋 No	spanic Ongin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)		4. Race - Ame Black, Whi Specify: 1/11		
12-0036	"natural		15. Decedent	1 (	16a. Decedent's Usual Occupation (Give kind of work done during most of working						Industry		
717	e filed within 7 al Hygiene. other than "r vent, the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Homemaker				0w	n Home		
<u> </u>	be file ital Hy id othe event,	Be	17. Father's Name (First, Middle,	•				18. Mother's Name			,		
Z	should and Men marke	일	Joseph Borrows Wat	19b. I	Mailin	g Address (Street a		Torreys			Zip Code)		
Na Na	1 and 2 s Health ar tem 27 Is		Robert Edmund Cam		- 1		lampton Fan					_,,	
Hore			20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal from State	1 .		sition (Name of natory or other place	, 00-100			ation - City or		
altill	permit. Pages Department of Important: If it any Injury or o		4 □ Donation 5 □ Other (S		Our Lady		Cemetery  Name and Addres	19, 2				Maryland al Home, P.A.	
ñ	Dep Imp any onc		Michael	X Hard	iner		O. Box 270						
	Physician		23a. Part1. Inter the disease, or shock, ir heart failure. List Immediate Cause (Final disease or condition	come ations the second only one cause of the line	e		the mode of dying		7	$\wedge$	CER	Approximate Interval Between Onset and Death	
,	/Medical Examiner		resulting in death)	Due to (or as a	consequence of							7,	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of	j.						1	
	ecuted and -transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	a consequence of	ence of);								
28/00,	ficate be executed physician and sthe burial-transii	edical E	d										
_	certifica nding ph use as th		IF FEMALE:										
O. BOX	death e atter	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live birth	23c. If yes, outcome pf pregnancy  1						23d. Date of delivery  Month Day Year		
as, r.	requires that the een signed by th nould be detache	by	Part II. Other significant condition	ns contributing to death bu	t not resulting in t	the un	derlying cause give	en in Part I.		Did tobacco use contribute to the cause of death?			
records	2 33 2	Completed							24a. Was	nsv 🌶 📗	24b. Were a prior to death?	utopsy findings available completion of cause of	
\ II a   I	sician: The law certificate has t irector, page 2 s		25. Was case referred to medical					26. Place of Deat		ormer? 212 No	1 ☐ Ye		
	Ja iš D	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatier	nt 2□ER/Outp	atien		er: 4 🗆 Nursing Ho		-	□Other (Sp	ecify)	
SION O	ding Physician: The h. After this certificate ha funeral director, page		27. Manner of Death  1 ☐ Natural 5 ☐ Pendin  2 ☐ Accident investic	28a. Date of Injury (Month, Day		me of ury	28c. Injury Work M 1□`	/ at :? Yes 2 □ No	28d. Describe	how injury	occurred		
DIVISI I	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Certification	2 Accident Investig	not be 280 Place of injur	ry - At home, farn . (Specify)	n, stre		_	28f. Location ( City or To	Street and wn, State)	Number or F	Tural Route Number,	
	Hospita 24 hours Funeral etely filled	Medical C		g Physician: To the best o Examiner: On the basis of and manner stat	examination and								
	To the within To the Compl	Me	29b. Signature and title of certified	100		$\gamma$	29c. License	number 4/72	8	29d. Date	signed (Mon	th, Pay, Year)	
			30. Name and address of person					11101	0	,	10	/ 3 0 0 0	
	Sta	te	Patrick Cross, M.D. 31. Date filed (Month, Day, Year)	24035 Three  32. Registra	Notch Road r's Signature	d, F	lollywood, l	Maryland 20	636				
	Registr		31. Date filed (Month, Day, Year) JAN 1 6 2008	Moon X.	front	•							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State	of Marylar			of Health of Death			giene Reg. No		023	319
	Physicia	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Ye									/ Year	3. Time of	Death
	/Medic		Marilyn Euge							1/1	1/20		8:04	a <sup>M</sup>
	Examin	er	4a. Facility Name (If not institutio			1		vn, or Location				County of Deat		
à	Funeral	200	Washington A 5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 \		r 24 Hrs.	8. Date of Bir	th	ontgome:	nplace (State	or Foreign
	Director		577-40-0434	1 ☐ M 21X F	7	6 Yrs.	Months D	ays Hours	Min.	3/20/1	931	Ashe	ville,	NC
put	3		Usual Residence of Decedent  10a. State 10b. County	/	10c Cit	ty, Town or Lo	cation						10d. Inside C	thy Limits
Maryla	fsho	ō		George's		erdale								2 □ No
the !	r 28a-	Director	MD Prince	e George s	5 KIV	eruare	10f. Zip Co	de			10g. Citi	izen of What Co	untry?	
death with the Maryland	23a o	ai D	5908 Cleveland	d Avenue				2073	7		U.S	.A.		
rdeat	ems er m	Funerai	11. Marital Status	12. Was Der Armed F	cedent Ever in U	.S. 13.	Was Deceden	of Hispanic O	rigin? (Sp	ecify Yes or No Rican, etc.)	)-	14. Race - American Indian, Black, White, etc.		
s afte	, or it	by Fu	1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yes G	2XINo		1 ☐ Yes 2 🗓			, ,			ite	
Z 15-UU36 thin 72 hours after	"natural", or items 23a or 28a-f show sideal, Examinst must be notified at			Year or I	Dates:	16a, Dece	dent's Usual C	ccupation			16b. Ki	ind of Business/		
	Martin	Completed		est grade completed	) (1-4or 5+)	/ Give	kind of work of DO NOT use r	lone durina mo	st of work	ring			,	
N P	giene er tha t, the	Com	11		(1 40. 01)	Offic	e Cler	ĸ			Aut	omotive	Dealer	rship
and d be file	d oth	Be	17. Father's Name (First, Middle,							e (First, Middle				
S bluof	d Men narke	P P	Charles Cambler Clayton  Philamena Lucy Chefaratti  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
Man de la se	th and	М	Royce H. McDev		anion		•					MD 2073		
<b>5</b> , a	f Healitam Standorther		20a. Method of Disposition	vice, com	20b. F	Place of Dispo	sition (Name	of 1	-	Date		cation - City or		
Page.	nt:#		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		1 State		,		_1/1	5/2008	Bre	entwood,	MD	
Saitimor Jermit. Pages	Department of Health and Mental Hygiene. important: If Itam 27 is marked other than any injury or other traumatic event, Itam inone.		21. Signature of Funeral Service					ddress of Facil				739 Bal		Ave.
n a	9 5 9		Claudet	te Dasce	Lar	12.12				e, P.A.		yattsvi.	lle, Mi	2078
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that t only one cause on	caused the deat each line.	h. So det ent	er the mode o	dying, such as	s cardiac	or respiratory a	rrest,		Approximate Interval Bet Onset and	te tween
	iysician Medical		Immediate Cause (Final disease or condition resulting in death)	a. C.	ere 23/	No 1	14000	1 F	Test	660			Onset and	Doam
	kaminer		, , , , , , , , , , , , , , , , , , , ,	Due to	ofor as a conseq	uence of):	1							
e <sup>n</sup>		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a conseq	uence of):	16 1 x3							
cuted	nd ransit	Examiner	triat iriitiated events	<b>S</b> .										
eeee	ohysician and the burial-transit	Ex	resulting in death) Last	Due to	(or as a conseq	uence of):								
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o X O	iding l	- മാ ⊦	IF FEMALE:	23c. If ves, or	utcome of pregna	ancy						23d. Date of deli	V00/	
death cer	a atter d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live	birth 2 ☐ Feta Inant at time of d	Ideath 3	Ectopic pregr Other (speci				4	Month		Year
) i	by the	hys	9 Unknown	9□ Unkı	nown									
es the	pe de	by F	Part II. Other significant conditi	ons contributing to	death but not res	ulting in the u	nderlying caus	e given in Part	1.			ise contribute to		
v requires	s uee s	ted								10	Yes 2	□ No 3 □ Pro	obably 4 🔯	Unknown
0	has b	Completed								24a. Was auto	psy	prior to d	topsy findings completion of c	available cause of
בי ב <u>י</u>	icete r, pag									1 ☐ Yes	ormed? 2 ☑ No	death? 1 ☐ Yes	2□ No	
VICAL Sicien: 1	certii	o Be	25. Was case referred to medica examiner?  1 ☐ Yes 2 ☑ No	Hospital:	Name of the second	ED/O		0.4		h (Check only				
2 g	eral d	n: To	27. Manner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time o		Injury at Work?		28d. Describe		6 ☐Other (Spec	city)	
g ig	ath. rr: Aft	atio	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	ng (Moi igation	nth, Day Year)	Injury	М	Work? 1 ☐ Yes 2 ☐	]No					
Y Affe	irscto irscto	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined   286. Plac	e of Injury - At he	ome, farm, str	eet, factory, of	fice		28f. Location ( City or To	Street an wn, State	d Number or Ru	ral Route Nun	nber,
٦ <del>ق</del>	urs af													
To the Hospitel or Attending Physicien:	within 24 hours after death.  To the Funerei Director. After this certificete has been signed by the attending pl tompletely filled in by the funeral director, page 2 should be detached for use as t	edicai	29a. Certifier 1∑ Certifyii (Check only one) 2 ☐ Medical	ng Physician: To th Examiner: On the l	e best of my kno basis of examina nner stated.	wledge, deati tion and/or in	n occurred at t vestigation, in	he time, date a my opinion, de	nd place, ath occuri	and due to the red at the time,	date and	and manner as i place, and due	stated. to the cause(s	s)
o the	omple	Me	29b. Signature and title of certifie		Thor stated:		29c. Li	cense number			29d. Dat	e signed (Month	n, Day, Year)	
	(1)		12/400	huso	12 /2		5	723	2		1/11	/2008		
	00		30. Name and address of person	1		n 23a) (Type,	Print)				,			
	D.		Dwayne Thompson	n 7600	Carrol	1 Ave.	Takom	a Park.	MD	20912				
	Sta		31. Date filed (Month, Day, Year,		Registrar's Signa		Tercon	a Lulky						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2008 /Medical Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hopkins Johns HOSPITA 8. Dale of Birth (Month, Day, Year)
April 28, Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** Months Hours 1 □ M 2 💢 F 75 186-28-9356 Director 1932 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County DC Washington 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3209 Gainsville Street, SE 20020 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Educator DC Public Schools 6 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gotlieb Lunsford Florence Artis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Cureton/Son 3209 Gainsville Street, SE Washington, DC 20020 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 11-18-2008 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street, NW 20011 Washington, DC 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Disseminate /Medical Due to (or as a consequence of): **Examiner** horacoabdomino Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ending physician and use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical ed by the attending properties of detached for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) ☐Yes 2. No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

(10)

State Registrar Blalock 650, 600 N. Wolfe

32. Registrar's Signature

-000

Street

Baltimore

W.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. Vallabha c syula 31. Date filed (Month, Dly, Year) JAN 15 2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene on one

			1 - State Amend #20b & 20c per	FH 01-	-22	2008 CNM erillicate of L	Death	Re	g. No.	3 02321			
			Decedent's Name (First, Middle, Last)     .					2. Date of Death Month		3. Time of Death			
	Physici: /Medic	_	Shirley ANN Do		15	T		January		5:38 I <sup>M</sup>			
	Examin	er	4a. Facility Name (If not institution, give street and number)										
	Funeral		7704 Carter Drive  5. Social Security Number 6. Sex 7. Ag	ge (In yrs. la:	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Maryland 9. Bi	rthplace (State or Foreign					
(Sa. 10)	Director		578-48-9407 1□ M 21XF	71	Yrs	Months Days	Hours Min.	July 7,		hington, DC			
	w w		Usual Residence of Decedent  10a. State 10b. County		10d. Inside City Limits								
	with the Maryland a or 28a-f show t be notified at	tor	Maryland Carroll		1 □Yes 2 ☑								
	or 28a	Director	10e. Street and Number	Sykes	, v .L.L.	10f. Zip Code		10	g. Citizen of What C	country?			
	ath wil	ral	7704 Carter Drive			21784			SA				
	er deg items ner m	Funeral	11. Marital Status  12. Was Decedent Armed Forces'  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒	?	. 1	<ol><li>Was Decedent of H If Yes, specify Cuba</li></ol>	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh				
936	urs aff al', or Exami	[호	3 Widowed 4 Noticed Size Year or Dates:	110		1 ☐ Yes 2 X No	Specify:		Specify: W	hite			
21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)		(G	ecedent's Usual Occup	durina most of worki		16b. Kind of Business	s/Industry			
121	within iene. than "	jd m	Elementary/Secondary (0-12) College (1-4or	· ·		e. DO NOT use retired	) -		Communica C	'lh om			
d 2	filed v Hygie other t	ပ္ပ	12 17. Father's Name (First, Middle, Last)		Arti	.st	18. Mother's Name		Ceramics S Maiden Surname)	пор			
lan		To Be	William Victor Strassberge	r			Margaret	Ann Bre	nnen				
Maryland	short and is m		19a. Informant's Name/Relationship (Type. Print)		19b. M	ailing Address (Street				Zip Code)			
	an eal eal		Michael Dottellis, son	20h Pla		Baker Value of Sposition (Name of			ick, Mary				
JOF	ages 1 nt of H : If iter		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	Pine	metery, c	crematory or other place ove Cemete	iv	l N	ft. Airy,	Maryland			
Baltimore,	permit. Pages: Department of Important: If ite any Injury or of		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	Tiea	sant	22. Name and Addre				<del>-Maryland</del> Funeral Home			
Ba	permi Depar Impor any Ir		Kyan h Der	Maryland									
	255		23a. Pa — Enter the disease, or complications that o use shick, or heart failure. List only one cause of a ach	d the death. line.	Do not	enter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death			
A	Physician		Immediate Causa (Final disease o concilion a. resulting in leath)										
	/Medical Examiner		Due to (or as	s a conseque	ence of):	1	120011	a. al.	3 mm.				
	25 2 3	ě	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	E S COURECIN	vice of):	ceare	voden	ay cos	Rane				
	cuted nd ransit	Examiner	that initiated events c.	val	l Artery Stenasis								
50,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	EX	resulting in death) Last Due to (or as	s a conseque	ence of):	•							
68760,	tificate I g physi as the k	edical	d	nevo	ug		-						
Box (	death certif attending i for use as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcom			оП <u>5-</u> 11			23d. Date of d	23d. Date of delivery			
	death	Physician/IV	in the past 12 months? 1 □ Yes 2 □ XNo  1 □ Unknown			3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	/		Month	Day Year			
P.0	res that the de signed by the a be detached t	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death	but not regul	ting in th	e underlying cause giv	on in Part I	23e Did tob	pacco use contribute	to the cause of death?			
	signe d be d	l by	GERD With	H4:	_				es 2 No 3 I				
Records,	w require been si should t	Completed	Hypoalbung		,			24a. Was a		autopsy findings available			
Re	The lav te has age 2:	omp	114100010000		1		·	autops perforr	ned? death?	o completion of cause of ? es 2 □ No			
or Vital		BeC	25. Was case referred to medical examiner?				26. Place of Deat						
or V	S S	P	1 Yes 2 No Hospital: 1 Inpat		R/Outpa 28b. Tim		4 LI Nursing Ho		ence 6 Other (Sp	pecify)			
	ing (fter	tion:	27. Manner of Death  1 Natural 5 Pending (Month, D)  2 Accident investigation		lnju	ry Wor	k? Yes 2 □ No	260. Describe no	w injury occurred				
Division	Atten r deat ector: by the	ifica	3 Suicide 6 Could not be 28e. Place of in	njury - At hon etc. <i>(Specify)</i>	ne, farm	, street, factory, office		28f. Location (St City or Town	reet and Number or I	Rural Route Number,			
Ö	F 후 두 드	Certification:	4 Tromote	atc. (Specify)				City of Town	., State)				
	To the Hospital or within 24 hours afte To the Funeral Dirt completely filled in the Funeral Dirt completely	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the besix 2 Medical Examiner: On the basis and manner s	t of my know of examinati stated.	/ledge, d on and/o	leath occurred at the tile or investigation, in my o	me, date and place, opinion, death occur	and due to the cred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)			
	To th withir To th comp	Me	29b. Signature and the of pertifier		<i>x</i> ' <i>x</i>	29c. Licens	e number	2	9d, Date signed (Mo	nth, Day, Year)			
)	0		Ky Cillier	12	T	1) - 0	00542	-18	1-15-6	2008			
	8		30. Name and address of person who completed cause of DR, Raman B Ka	death (Item :	23a) (Ty	349 Mal	calm di	ine, we	erbunnit	4 MD			
Check only one)   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.   29c. License number   29d. Date signed   29d. Date													

permit. Pages 1 and 2 should be filed within 72	Department of Health and Mental Hygiene.	Important: If Item 27 is marked other	any injury or other traumatic event, the Medi
/ Ex	y: Mo	ed mi	cia ica ine
		l a	
pltal or Attending Physician: The law requires that the death certificate be executed	irs after death,	eral Director: After this certificate has been signed by the attending physician and	illed in by the funeral director, page 2 should be detached for use as the burial-transit

	1	For State Registrar		State of	Marylan		ertificate of				giene Reg. No. 2	008	02322
Physician /Medical		1. Decedent's Nam	ne (First, Middle, I							2. Date of Dea Month 01/13	Day 2008	Year	3. Time of Death  07:20P <sup>M</sup>
Examiner				nive street and numb			4b. City, Town, o		of Death		4c. Co		
Funeral Director		5. Social Security I  043-24-5  Usual Residence of	5755	Sex 7 1. TMM 2. F	Age (In yrs. 76	last birthday Yrs.	Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day 08/05/	Year)		nplace (State or Foreign untry)  MA
Maryland -f show lied at		10a. State 10b. County 10c. City, To					ocation.						10d. Inside City Limits 1 □ Yes 2 X No
ms 23a or 28a-f show must be notified at	3 -	10e. Street and Number 24204 DRAYTON LANDING DR.					10f, Zip Code <b>21678</b>						
i e i	2 .	11. Marital Status 1 ☐ Never Mar 3 ☐ Widowed	ried 2 X Married	12. Was Deced Armed Forc 1 XYes 2 If Yes, Give Year or Date	es?	.S. 13.	. Was Decedent of H If Yes, specify Cuba 1  Yes  No	lispanic Ori an, Mexica Specify:		cify Yes or No- Rican, etc.)		Race - Amer Black, White ecify:	
ed within 72 hours are Ygiene. Per than "natural"; or t, the Medical Exami	-		15. Decedent's cify only highest of	Education		16a. Deci	edent's Usual Occup e kind of work done DO NOT use retired	during mos	st of workin	g	16b. Kind o	of Business/I	
and Mental Hygiene. Is marked other than "na aumatic event, the Media		12 17. Father's Name	SPACE ENGI	18. Mothe	DEFENSE ther's Name (First, Middle, Maiden Surname) ADELINE EMERSON								
If and Men  27 Is marke  traumatic		PHILIP I	lame/Relationship				ling Address (Street	and Numb	er or Rural	Route Numbe	r, City or To		
pennin. rages l'anua Department of Health Important: if Item 27 I any injury or other tra once.	1	20a. Method of Dis 1 ☐ Burial 2		☐Removal from St	ate C	Place of Disp cemetery, cre	OST OF STREET OF	ce)	Da	ate	20c. Locati	on - City or	Fown, State
Departme Importan any injur	-	21. Signature of Funeral Service Licensee  22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 130 SPEER RD. CHESTERTOWN, MD 21620											
hysician /Medical	23a. part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of):									1620	Approximate Interval Between Onset and Death		
Examiner		Sequentially list concause. Enter Und Cause (Disease of that initiated event	onditions, erlying	SW Wence of):	9						2 Wks.		
physician and the burial-transit dical Examiner	i	Cause (Disease of that initiated event resulting in death)	s Last	cDue to (or	quence of):								
attending process or use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify, outcome pf pregnancy)											
m 0 1.													
ate has	Aiscose, Carotid Stenosji, Chromic rend insuffic 24a. Was an autopsy performed?  LaPD 24b. Were a prior to death?  1 1 0 0 0 1 1 0 0 1 1 0 0 1 1 1 0 0 1 1 1 0 0 1 1 1 0 0 1 1 1 0 0 1 1 1 0 0 1 1 1 0 0 1										topsy findings available ompletion of cause of 2D No		
this id		25. Was case refe examiner? 1 Yes 27. Manner of Dea	No.	Hospital: 1 Inp	Injury	28b. Time	ent 3 DOA Oth	er: 4□ Nu	ursing Hom	(Check only or ne 5 Resid 8d. Describe h	ence 6 🗆	Other (Spec	rify)
within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral Medical Certification:		1 Natural 2 Accident 3 Suicide 4 Homicide	5 ☐ Pending investigati 6 ☐ Could not determine	on be 28e. Place of	Day Year) injury - At ho , etc. (Specif	Injury ome, farm, si		k? Yes 2∐		8f. Location (S City or Tow	treet and Ni n, State)	umber or Ru	ral Route Number,
in 24 hours in 24 hours pletely filled		29a. Certifier (Check only one)	Certifying I	Physician: To the beaminer: On the bas and manne	is of examina	wledge, dea tion and/or i	th occurred at the tir nvestigation, in my o	me, date ar opinion, dea	nd place, a ath occurre	nd due to the ded at the time, o	ause(s) and date and pla	d manner as ice, and due	stated. to the cause(s)
To the comp		29b. Signature and	title of certifle	<b>)</b>	Mo		29c. Licens	e number	35	2	29d. Date si	gned (Month	
		Frede	rack D		of death (Item	23a) (Type	Church	Hall	Rel.	Ches	terto	Un, r	1D 21620
State Registrar		31. Date filed (Mor		5 2008 >	is p's Signa	ture	Church		7				

			For State Registrar	State of Mi	arylanu /		tificate of		,	giene Reg. No	008	02323	
Ş	Physici	an	1. Decedent's Name (First, MARGARET CHA					-	2. Date of De Month 01/1:		Year	3. Time of Death	
1000	/Medic Examir	al		tution, give street and number)		4b. City, Town, o			4c. C	Ocunty of Deatl	Day Year  Day Year		
	Funeral Director		5. Social Security Number <b>217–16–4805</b>	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year)	· MD				
	yland how at		Usual Residence of Deceder 10a. State 10b. Co		10c. City, Tov	wn or Loc	ation					10d. Inside City Limits	
	he Mar 28a-f sl otified	Director	MD KE	NT .	CHES	TERT	OWN 10f. Zip Code			10a Citiz	en of What Co		
	h with i	ai Dir	10e. Street and Number  2020 HERON	POINT			21620			Tog. Citize	USA	unity:	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funerai	11. Marital Status 1 □ Never Married 2□ 3 ▼Widowed 4□ Divo	If Yes, Give			Vas Decedent of H Yes, specify Cuba	lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		4. Race - Amer Black, White Specify: WE		
21215-0036	א 72 ho "natur edical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)		16	(Give F	ent's Usual Occup kind of work done O NOT use retired	during most of we	orking	16b. Kin	d of Business/	Industry	
212	d withir giene.	omo				OMEM				OWN HOME			
	I be filed ntal Hygi ed other event, ti	Be	17. Father's Name (First, Min					18. Mother's Na	me <i>(First, Middle</i>	, Maiden S	Surname)		
Maryland	2 should and Men is marke aumatic	T <sub>0</sub>	19a. Informant's Name/Rela		19	9b. Mailin	g Address (Street		Rural Route Numb	er, City or	Town, State, Z	Zip Code)	
ž ć	and 2 lealth a m 27 is		J. TYLER CAM	PBELL/SON			IGH ST.	CHESTERT	OWN, MD			Town State	
Baltimore,	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 【Crema 4 ☐ Donation 5 ☐ Oth	tion 3 Removal from State	cemet	tery, crem	atorý or other plac	1					
alti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Se		CHESA	22.	Name and Addre	ss of Facility					
	20 E # 9		23a Port 1 Enter the disease	se or complications that caused	the death Do	1	<u>30 SPEER</u>	RD. CHE	STERTOWN	, MD	21620		
)	Physician /Medical												
	Examiner		Sequentially list conditions,	b								P.	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence	e or):							
90,	tificate be executed g physician and as the burial-transit	l Exa	resulting in death) Last	Due to (or as	a consequence	e of):							
68760,	ificate by physical properties of the control of th	edical		d									
Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown  3 ☐ Ectopic pregnancy 5 ☐ Other (specify)							23d. Date of delivery  Month Day Year			
<u>S</u>	es that igned by be deta	by Ph	Part II. Other significant co		23e. Did tobacco use contribute to the cause of death?								
Sord	w requir been si should	eted							24a, Was	1 Yes 2 No 3 Probably 4 Unknown			
Re	The lay	Completed							auto		prior to death?	completion of cause of	
Vita	ician: certifica ector, I	Be	25. Was case referred to me examiner?	Hospital:			3□ DOA Oth	or:	ath (Check only	оле)		•	
0	g Phys er this eral dir	n: To	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Inju	iry 28b.	. Time of	3 □ DOA Our 28c. Injur Wor	4 Nursing	Home 5 ☐ Resi 28d. Describe			cify)	
Division or	tending eath. or; Aft the fun	catio	Z L Accident	vestigation		Injury	M 1 🗆	Yes 2 No					
DIX	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	4 ☐ Homicide de	etermined 256. Place of Injury	c. (Specify)		et, factory, office		City or To	wп, State)		ıral Route Number,	
	e Hosp 124 hou e Fune letely fil	Medical	(Check only 2 ☐ Med one)	tifying Physician: To the best lical Examiner: On the basis o and manner st	f examination a ated.	and/or inv	estigation, in my o	opinion, death oo	curred at the time,	date and	place, and due	stated. to the cause(s)	
)	To the within To the Comp	Me	29b. Signature and title of ce	rison who completed cause of do k, M1D , 23  Year) 32. Region 1 5 2008	- Mr	)	29c. Licens	00415	587	29d. Date	signed (Monti	h, Day, Year)	
			30. Name and address of pe	rson who completed cause of do	leath (Item 23a)	(Type, F	Print) Che	stertoun	, MD.	2162	0		
	Sta	te	31. Date filed (Month, Day,	Year) 32. Regi	ar's Signature	La .	Sec. 11's	<u> </u>					
But	Registr	ar	JAI	1 1 5 200B	Enso &	J. A.							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death Year **Physician** MARTHA 352 PM DAVIS 08 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE UMVERSIT OF MARYLAND 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🖺 F Director 547-50-4248 December 12, 1936 Harrell, Ark. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20602 United States 4945 DEAL COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 월 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Black altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 Nidowed 4 Divorced Completed Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature any injury or other traumatic event, the Medical once." 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Social Worker +2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Bunn ၉ Stella Tate 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4945 Deal Court Waldorf Maryland 20602 Andre J. Davis - Son 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/15/2008 Brentwood Maryland Ft Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pope Funeral Home Signature of Funeral Service Licens 5538 Marlboro Pike Forestville Maryland 20747 DOW THE MEDICAL EXAMINER oproximate hterval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** TRANMATIC BRITIN FNTKPY /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy signed by the atte in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 on blood 1 Yes 2 No 3 Probably 4 Unknown STREKE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy page 1∏ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical the funeral director To Be 26. Place of Death (Check only one) Other: 1 PYes 2 No 1 ☐ Japatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ № 6 1000 P M 2 Accident 04/08 FALL 01 after death Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28e. Place of injury 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide within 24 hours afte

To the Funeral Di 4945 DEAL CT WALDORF, MD 20602 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

State Registrar

29b. Signature and title of certifier

30. Name and address of person

MAYUR

NARRYAN 31. Date filed (Month, Day, 32. Registrar's Signature JAN 1 6

no completed cause of death (Item 23a) (Type, Print)

22

SOUTH

GREENE

29c. License number

18239

STREET

29d. Date signed (Month, Day, Year)

01

MO

PARTIMORE

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2120

08

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician January 11, 2008 Albert Francis Davis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center Leonardtown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**№** M 2□ F 217-28-8081 78 Director September 12,1929 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location Maryland Leonardtown St. Mary's Director 10e. Street and Number 10g. Citizen of What Country? 22600 Breton Bay Drive 20650 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: ۾ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Albert Davis Mary Ella Simpson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Ann Davis / Wife P.O. Box 103 Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State January 15, St. Aloysius Cemetery 4 □ Donation 5 □ Other (Specify) Leonardtown, Maryland 2008 21. Signay re of Funeyal Service Lipensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. LUNG CANCER Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the buriat-trar Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERY DO (ENER CORONADY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

Be ို

Certification:

Medical

								-	autopsy performed? 1□ Yes 2☑No	prior to completion of cause of death? 1 □ Yes 2 □ No		
25	. Was case refer	red to medical		26. Place of Death (Check only one)								
	examiner? 1 ☐ Yes 2 ☐	No	Hospital: 1 ☐ In	patient 2	] ER/Outpatient	3□1	OOA Other: 4 Nursing	Home	5 ☐ Residence 6	□Other (Specify)		
27	. Manner of Deatl 1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation	1	f Injury , Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	280	d. Describe how injury	occurred		
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place o	of injury - At h g, etc. <i>(Speci</i>	ome, farm, stree	et, fact	ory, office	28f	Location (Street and City or Town, State)	Number or Rural Route Number,		
29	a. Certifier (Check only	1. Certifying Ph 2 Medical Exam	ysician: To the t	est of my kno sis of examina	owledge, death ation and/or inve	occurre	ed at the time, date and pla on, in my opinion, death oc	ce, and	d due to the cause(s) a at the time, date and	and manner as stated. place, and due to the cause(s)		

and manner stated.

D 56096

29d. Date signed (Month, Day, Year) 1-11-08

10:00<sup>A</sup> M

St. Mary's

Maryland

White

USA

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1X Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAJBINDER 5 GILL

20236, HUNTWOOD MI

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Registrar's Signature

			State of Maryland / Department / Department / Department / Department / Department / Department		ental Hygi	ene	> (
	(k)		Registrar  1. Decedent's Name (First, Middle, Last)	tificate of Death	2. Date of Death	g. No. 2 0 0 0 2 3 2	h
	Physici		Raoul Kenneth Denton		Month January	Day Year	M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			37980 Lawrence Place	Mechanicsville		St. Mary's	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 948–38–0750 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 9. Age (In yrs. l	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, ) 08/25/19	Year) 9. Birthplace (State or Fore Country) 48 Connecticut	sign
	and ow t		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Lim	iits
	h the Marylan r 28a-f show notified at	tor	Maryland St. Mary's Mechanics	sville		1	No
	th the or 28s	Directo	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?	
	ath wi	lal	37980 Lawrence Place	20659		United States	
326	be filed within 72 hours after death with the Maryland tal Hyglene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	Armed Forces?    Married   Armed Forces?   I   Yes 2   No	Vas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto f □ Yes XX No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White	
215-0036	within 72 hor ene. than "natura he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) (Give life. L	lent's Usual Occupation kind of work done during most of workir DO NOT use retired)	ng   16	6b. Kind of Business/Industry	
7	filed witl Hygiene other tha ent, the	Com	12 Saftey	Specialist		S Government	
yland	be filed ntal Hygi od other event, ti	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		aiden Surname)	
Ĕ	hould be id Menta marked matic ev	은	Unknown  19a. Informant's Name/Relationship (Type. Print)  19b. Mailin	Beatrice g Address (Street and Number or Rura		City or Town State Zin Code)	
<u>8</u>	nd 2 s ilth an 27 is r trau			B Erin Drive Mecha			
ě,	of Hear		20a. Method of Disposition 20b. Place of Dispos			Oc. Location - City or Town, State	
Ē	Page ment of ant: If ury or		4 Donation 5 Other (Specify) Brinsfield	l-Echols Cre 1-21-		harlotte Hall, MD.	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 Is marked any injury or other traumatic enone.		21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22	Name and Address of Facility Bri 2955 Hollywood Road	nsfield d Leonar	Funeral Home PA. dtown,Maryland 2065	0
	Physician (Madical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	1 10	r respiratory arres	Onset and Death	14
	/Medical Examiner	_	Due to (or as a consequence of):			•	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
Š,	icate be executed physician and the burial-transit	Exa	resulting in death) Last  Due to (or as a consequence of):	10			
28/60	icate t physic s the b	dical	d				_
.C. BOX	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after cleath.  To thin 24 hours after cleath.  To the Furbard Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	ysician/Me		Ectopic pregnancy		23d. Date of delivery Month Day Year	
S,	The law requires that the ate has been signed by the page 2 should be detache	by Phy	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		acco use contribute to the cause of death?	
ecords,	aw requi	Completed			1 ☐ Yes 24a. Was an	24b. Were autopsy findings availa	ble
r	The late has page	Som			autopsy performe 1∐ Yes 2	prior to completion of cause of death?  Location of cause of death?  Location of cause of death?	Σľ
Vital	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death	(Check only one)	)	_
5	Phys	. To	1		ne 5 Residen 28d. Describe how	nce 6 Other (Specify)	
SION	Attending or death. ector: After by the fune	tion	1 Matural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 □ Yes 2 □ No	Lod. Describe now	virgary occurred	
בואות	al or Atter after dea I Director d in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, streen building, etc. (Specify)	et, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death death one)  Medical Examiner: On the basis of examination and/or invand manner stated.	occurred at the time, date and place, a restigation, in my opinion, death occurred.	and due to the cau ed at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)	
	To th To th	Me	29b. Signature and title of cartifler	29c. License number	290	d. Date signed (Month, Day, Year)	
			* /M	014285		1-21-08	
	,,			Print) Leonardtown, Maryl	and 2065	0	
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2 3 2000  22. Registrar's Signature	W			

DHMH 17 Rev 1/2001

08-00226
William B. Davis
Physicia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 02327

		I- For State Registrar		Cert	tificate of	Death		F	Reg. No.	000 0202
Physicia Medical Examir	n/	1. Decedent's Name (First, Middl WILLIAM		VIS				2. Date of Dea Month January 8	Day Year 3, 2008	1131 Nrs
		<ol> <li>Facility Name (if not institution</li> <li>4800 Quimby Avenue</li> </ol>	_	r)	4	b. City, Town, o Beltsville	r Location o	f Death	4c. County of Prince G	
Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. Ia	st birthday)	If Under 1 Yea		r 24Hrs. 8. Date of B	irth (MM/DD/YYYY)	9. Birthplace (State or ForeignかA SHT NGTON
Director	ļ	578-56-4557	1X M 2 F	64	Yrs.	Month's Day	riours	SEPT.	10 1943	Foreign ASHINGTON Country) DC
any	ł	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Location	on				10d. Inside City Limits
Maryland 28a-f show any d <u>at once.</u>	ŏ		E GEORGE'S	BEI	LTSVILLI					1 X Yes 2 No
15-0036 filed within 72 hours after death with the Maryland I Hygiene. I other than "natural", or items 23a or 28a-f sho i, the Medical Examiner must be notified at once.	Director	10e. Street and Number 4800 QUIMBY AV	ENUE			10f. Zip Code 20705			10g. Citizen of What USA	at Country?
ms 23a		11. Mantal Status	12. Was Deceder			Decedent of Hi		in? (Specify Yes or N		- American Indian, Black,
er death	Funeral		Armed Forces  1 X Yes  vorced If Yes, Give Year		IAVY	Yes 2 x No		Puerto Rican, etc.)	White,	
ours aft atural"	è è	15. Decedent's Education (Spe	or Dates:	ompleted)	16a. Decedent	's Usual Occupa	tion (Give k	kind of work done	Specify:	BLACK siness/Industry
36 in 72 he han "in lical Ex	Completed	Elementary/Secondary (0-12)	College (1-4 o	r 5+)	·	st of working life		use retired)		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	튅	12TH 17. Father's Name (First, Middle,	, Last)		WARE 1	HOUSE W		s Name (First, Middle,	PRIV Maiden Surname)	
215 be fill mtal H rked	Be	ALLEN	DAVIS						JAMES	
MD 21 d 2 should th and Me n 27 is ma numatic en	위	19a. Informant's Name/Relations CANDACE DAVI	ship (Type, Print)		19b. Mailing 6161			ber or Rural Route Nu # 5 RIVER		n, State, Zip Code) YLAND 20737
	ŀ	20a. Method of Disposition			lace of Dispositematory or other		emetery,	Date	20c. Location -	City or Town, State
Baltimore, permit. Pages 1 an Department of Her Important: If ite		1 X Burial 2 Cremation 4 Donation 5 Other St	pecify:	state	VETER	ANS CEM	ETERY	1/16/2008	CHELTEN	NHAM, MARYLAND
Balti permit. Departr Import		21. Signature of Funeral Service	Licensee					J. B. JEN		
Physician		23a. Part I. Enter the disease, or		ed the death.				ROAD LANDO' ardiac or respiratory a		art Approximate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease	a. Atherosclerotic			ease				Between Onset and Death
. )		or condition resulting in death)	Due to (or as a con	sequence of	):					
	ije	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con	sequence of	):					
ed sit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of	):					
760, Ticate be executed by physician and the burial - transit		UNPENDED	d AMENDED							
8760, ifficate be ng physici as the buri	/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outc				m- 11		23d. Date of	
00 ∄ ≋ ≋ 1	Physician/Medical	past 12 months?	4 Pregnant	at time of dea		al death 3 er (Specify)	Ectopic	pregnancy	Month	Day Year
O.O. Bo that the dea ned by the a detached fo	Phys	1 Yes 2 No 9 Uni	known 9 Unknown	ath but not re	sulting in the u	nderlying cause	given in Pa	rt I. 23e. Did	tobacco use contri	bute to the cause of death?
ires that the signed by I be detach							<b>J</b>		es 2 No 3	Probably 4 Unknown
Cords.	Completed by							24a. Wa:	ppsy p	Vere autopsy findings available inor to completion of cause of
Reco										leath?  Yes 2 No
Vital Rec ysician: The I his certificate I director, page	Be	25. Was case referred to medica examiner?	Danidal	tient 2	ER/Outpatient		of Death	(Check only one)  Nursing Home 5	Residence 6	Other: Scene
of Viding Physic	٩	1 Yes 2 No 27. Manner of Death	28a. Date of Ir (Month, Day		28b. Time of In		ury at Work		how injury occurre	
sion trendir death. etor: A	atio	1 Natural 5 Pend 2 Accident Inve	ding estigation				Yes 2			
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sted in by the funeral director, page 2 should tal	Certification:		ld not be 28e. Place of (Specify)	Injury - At ho	me, farm, stree	t, factory, office	building, et	c. 28f. Location or Town,		er or Rural Route Number, City
Division of Vital Records, P.O. Box 6 within 24 hours after death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendict completely filled in by the funeral director, page 2 should be detached for use	Medical Co	29a. Certifier 1 Certifying P	hysician: To the best of aminer: In the basis of examiner and pranner state	amination ar						
~	B	29b. Signature and title of certifie		**			se number		İ	ed (Month, Day, Year)
8			Shul			0.0	.M.E.		January 9,	2008
ge +1		<ol> <li>Name and address of person David Fowler M.D.</li> </ol>	who completed cause of Chief Medical Exar		<sup>23a)</sup> 11 Penn Sti	reet, Baltimo	ore, MD 2	21201		
Sta Regist	ate	31. Date filed (Month, Day Year) JAN 1 5 2008	32. Regist	rar's Signatu	re					
DHMH 17 Rev 1/20			Julian 1	19	ORIGINAL					

08-00315 Jane

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 02328

et Ruth Evar		1- For State Certificate of Death Reg. No.			
Physici	an/	Registrar  1. Decedent's Name (First, Middle,Last)  1. Decedent's Name (First, Middle,Last)  1. ANFT RITH EVANS  2. Date of Death Month Day Year January 11, 2008  3. Time of Death Month Day Year January 11, 2008			
dical Exami	ner	4b. City, Town, or Location of Death 4c. County of Death			
l arr		St. Marys Hospital  Leonardtown  St. Mary's  Leonardtown  St. Mary's			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1			
ý		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits			
d now any e.	L	Maryland St Mary's California			
laryłan 18a-f sl at ono	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?			
with the Maryland ms 23a or 28a-f show be notified at once.					
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. Tis marked other than "natural", or items 23a or 28a-f sho anaite event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1			
fter death I", or iten	y Fu				
nours a natura (x mir	Completed by	15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry			
36 nin 72 l e. Ihan ", dicat I	plet	Elementary/Secondary (0-12) College (1-4 or 5+)  12th Customer Service Giant Foods			
5-00 ed with tygiene other	Con	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)			
MD 21215-0036 d 2 should be filed within 7 line and Mental Hygiene n n 27 is marked other than rumatic event, the Medica	o Be				
LD 2 2 shoul 1 and M 27 is m	۲	John F. Evans, Jr./son 8039 N County Rd. Freetown, IN 47325			
- p = E E E		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Education - City of Town, state			
Baltimore, permit. Pages 1 at Department of He Important: If ite		4 Donation 5 Other Specify: Cedar Hill Cemetery   O1-10-2008   Sultiland, Halfiland			
Balti ermit. Departr import		1 900 - 14 1 Mo 1374   Coder Hill FH 4111 PA Ave. Suitland, MD 20746			
Physician		23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and			
ledica amine		failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease			
e e e e e e e e e e e e e e e e e e e		or condition resulting in death)  Due to (or as a consequence of):			
	يَة	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):			
	Examiner	c. (Disease or injury that initiated c. Due to (or as a consequence of):			
recuted n and transit					
60, ate be execut hysician and	i	UNPENDED AMENDED 23d. Date of delivery			
876( tificate ng phy	Physician/Medical	FFEMALE:   23c. If yes, outcome of pregnancy   Month   Day   Year   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Year   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Year   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Year   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Year   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Year   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1	that the death certificated by the attending phenomenal by the attending phenomenal for the act the	i dia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 V Unknown  g Unknown
D. B. It the de by the	4				
ires that the signed by		■ Lymphoma			
Division of Vital Records, tat or Attending Physician: The law requirers after death.		autopsy prior to completion of cause of			
Reco The law	, page 7	1 Ves 2 No 1 Ves 2 No 26.Place of Death (Check only one)			
Vital Reco		25. Was case referred to medical examiner? Hospital: Inpatient 2 FR/Outpatient 3 DOA Other:			
of Vi	Herar or	1 V Yes 2 No  28a Date of Injury  28b. Time of Injury  28c. Injury at Work?  28d. Describe how injury occurred			
on or tending sath.	me rui	Natural 5 Pending Investigation See Place of Injury - At home farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Cit			
ivisi I or At after d	yo ui E	Suicide 6 Could not be 256. Take of mighty Attacks and Suicide or Town, State)			
Ospital hours	y tille				
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and the Funeral Director: After this certificate has been signed by the attending physician and the Funeral Director: After this certificate has been signed by the attending physician and the Funeral Director: After this certificate has been signed by the attending physician and the funeral Director: After this certificate has been signed by the attending physician and the funeral Director: After this certificate has been signed by the attending physician and the funeral Director of t	mplete	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cass(s)			
5 ½ €.	8	1 // // // // // // // // // // // // //			
6		Muna Brassell, 1005			
By		30. N me and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
	Sta	24 Subflict 44 (f. Society) 32 Penistrat's Signature			
		TRALT NO FILES FOR I AND MARKET NO.			

ORIGINAL

OCME

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Req. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 10, 4:43PMM January Charlotte Eskridge /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Somerset Princess Anne Manokin Manor Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | 09/17/1928 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Funeral Country)
Maryland 1 □ M 2 1 F Yrs. Director 79 221-18-1273 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County in than "natural", or Itams 23a or 28a-f show the Medical Example roust be notified at 1) Yes 2 □ No Director Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21853 11974 Edgehill Terrace · death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withit Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than any injury or other traumatic. Elementary/Secondary (0-12) College (1-4or 5+) Dupont Quality Control 12 none Lab Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mildred Wheatley Cleophus Eskridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14129 Allen Road, Princess Anne, MD 21853 Florence E. Davis/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 01/11/2008 Salisbury, Maryland Signature of Funer of Perv of Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853 Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CVA /Medical Due to (or as a consequence of): Examiner 73CVI) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ō Year in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 🗌 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 70 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Certification: 5 Pending investigation 1 X Natural 2 Accident death. 1 Tes 2 No Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To tha Funaral C 29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15/08 D47094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vel Nateson M.D. 1415 South Division St., Salsibury, MD 21804 State Eleve & Species Registrar

Division or Vital Records, P.O. Box 68760

26. Place of Death (Check only one)

Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

1 Yes 2 No

27. Manner of eath

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

29c. License number 00037066 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of geath (Item 23a) (Type, Print) 0

6188 0 xon Hill &d. #701 0xon Hill, mp 20745

State Registrar

Certification: To

31. Date filed (Month, Day, Year) JAN 3 0

Hospital or Attending

within 24 hours after death

To the Funeral Director:

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

_				partment of Health and Mental Hygiene ortificate of Death	331
	Physic	ian	1. Decedent's Name (First, Middle, Last)  Jack Thomas Gnegy	2. Date of Death 3. Time of Month Day Year	of Death
	/Med Exami		Y	4b. City, Town, or Location of Death 4c. County of Death	_A M
	LAdini	i ici	Garrett Co. Memorial Hospital	Oakland, MD Garrett	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1974) 77 Yrs.	) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State Country)	or Foreign
	Director		Usual Residence of Decedent	06-26-1930 Davis, W	V
	arylan show	Ļ	10a. State 10b. County 10c. City, Town or L	754. 11566 0	ity Limits
	the M	ecto	WV Tucker PO Box	20200 R	2 No
	3a or	Dir	8th street	10f. Zip Code 10g. Citizen of What Country? US	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Exerciner must be notified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.	
36	irs afte	by Fu	1 Never Married 2 Married 1 Never S 2 No If Yes, Give 9 Year or Dates:	Slack, White, etc.  □ Yes 2 No Specify: Specify: Specify: White	
9	72 hou	ted	15. Decedent's Education 16a. Dece	ident's Usual Occupation 15b Kind of Rusingsofindustry	
12	vithin ne.	Completed	(Specify only highest grade completed) (Give life.  Elementary/Secondary (0-12) College (1-4or 5+)	okiria or work done during most of working DO NOT use retired)	
о 5	be filed value Hygie od other to	CO	12th grade Mill  17. Father's Name (First, Middle, Last)	Wright Bethhelem Stee:	1
/lan	uld be Mental Irked (	To Be	77 7 . 07 . 0	Annie Hill Forsythe	
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
	1 and Health Iem 27		Garrett Co. Memorial Hosp. 251  20a. Method of Disposition 20b. Place of Disposition	N 4th St. Oakland, MD 21550	
Baltimore,			1 X Burial 2 Cremation 3 Removal from State Cemetery, cres	Date 20c. Location - City or Town, State 20c Davis, WV	
a	permit. Page Department of Important: If any Injury or once.	i		Name and Address of Facility Linkle Funeral Home PO Box 186	
	20F#9		23a. Part 1. Exter the disease, or complications that caused the death. Do not ent	Davis, WV 26260	
			23a. Part I. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	Interval Bet	ween
	Physician / /Medical		disease or condition resulting in death)  a. Pro+eus multiple in death)  Due to (or as a consequence of):	abilis bacternia with onser and	_A_
	Examiner		Sentic	shock Twe	eks
0 -	ted sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	choosis all deline	0
20	be executed icien and burial-transit	Examin	that initiated events resulting in death) Last c. Due to (or as a consequence of):	chronic alcoholeem year	2
8/60	cate be executed physicien and the burial-transit	dical	d		
ox ox	leath certific attending pl	/Med	IF FEMALE:		
9	death of attention of for us	cian		□Ectopic pregnancy 23d. Date of delivery □ Other (specify) Month Day Y	/ear
j.	at the c by the	Physician/Me	9 ☐ Unknown 9 ☐ Unknown		
S,	law requires that the death certificate as been signed by the attending phys. 2 should be detached for use as the i	by	Part II. Other significant conditions contributing to death but not resulting in the ur	4. ()	
cords	w requir been si should	Completed	alocation of the	ere, elliphysema 180 es 2 No 3 Probably 4 DU	nknown
Ľ	The lar	omp	cessiviai um organiele, al	The Stword 24a. Was an autopsy performed? 24b. Were autopsy findings a prior to completion of ca death?	available ause of
	ian: artifice ctor, p	BeC	25. Was case referred to medical examiner?	1 Yes 2 No 1 Yes 2 No	
5	Physic this ce al dire	ဥ	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatien	The state of the s	
5	ding th. : After funer	tion	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation	28c. Injury at Work?  M	
2	Atter er dea rector by the	Certification:	3 Succide 6 Could not be determined 28e. Place of Injury - At home, farm, stre	eet, factory, office 28f. Location (Street and Number or Rural Route Number)	ber,
5	intal or urs afte rai Din lled in		- Building, etc. (Specify)	City or Town, State)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 and 10 hours.	Medical	29a. Certifier  (Check only one)  Check only one)  Check only one)  Check only one)	occurred at the time, date and place, and due to the cause(s) and manner as stated.  /estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
	within To the comple	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)	
•			Margout a Daiser id	D26650 1/23/2008	
	0		30. Name and address of person who completed cause of death (Item 23a) (Type, I	D26650 1/23/2008 Squett hishway cahland, Md215	
US E	Sta	te	31. Date filed Month, Day, Year) 32 Registrar's Signature	SANOTT MISHWAY CANLOWS, MODIS	50
	Registra	7	IAN 3 0 2008 1000 1000 1000 1000 1000 1000 10		

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			State of Maryland / Department	artment of Health and N rtificate of Death		00000000
			- negistra:	runcale of Dealif	2. Date of Deat	b 3. Time of Death
4.	Physicia	an	1. Decedent's Name (First, Middle, Last)		Month	Day Year
Y.	/Medic		Ulysses Grant Garland 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	January	8, 2008 4:50 P <sup>™</sup> 4c. County of Death
	Examin	er		Rockville		Montgomery
	Funeral		Casey House 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	9 Birthplace (State or Foreign
þ.	Director		579-26-5525 1XM 2□F 81 Yrs.	Months Days Hours Min.		
1100	P.		Usual Residence of Decedent	ocation		10d. Inside City Limits
	arylar show d et	_	100.000			1√∑Yes 2 No
	8a-f	Director	Maryland Prince George's Adelphi	10f. Zip Code	11	0g. Citizen of What Country?
	with t		10e. Street and Number	20783		United States
	eath	Funeral	9200 Edwards Way #1600  11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - American Indian,
	r Iten	Fu	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	Black, White, etc. African
036	urs a ei", o Exer	by	If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: American
2	72 ho natur fical	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work		16b. Kind of Business/Industry
7	ithin "er.	μ	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		G
2	led w lygiel her tl nt, th		8 years Dire	ector of Manpower	ne (First, Middle, I	Government (Dept. of Maiden Surname)
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygene. is marked other then "naturel", or Items 23a or 28a-f show is marked other then "naturel", or Items 20a or 28a-f show aumetic event, the Medical Exeminer must be notified at	Be	Henry C. Garland		n Shank1	,
Ž	hould d Me mark metic	은		ing Address (Street and Number or Ru		
ĭ			1 1 1 1	- Q Street, NE Was		
ē,	permit. Pages 1 and 2 Department of Health s Important: If item 27 is eny injury or other tra		20a. Method of Disposition 20b. Place of Disposition	osition (Name of ematory or other place)	Date	20c. Location - City or Town, State
E	Page lent o nt: If		I 1 Harrial 2   ICremation 3   IHemoval from State	iemorial Park Jan.	14, 200	8 Landover, MD
Baltimore,	permit. DepartmImportal		21. Signature of Funeral Service Lichus 2	2. Name and Address of Facility St		
m	Pe E E		What I woward I			hington, DC 20019
			23a. Part1. Soler the disease, or complications that caused the death. Do not en shock, of heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac	or respiratory arr	est, Approximate Interval Between Onset and Death
7	Physician		Immediate Cause (Final disease or condition Pneumonia			
	/Medical Examiner		Due to (or as a consequence of):	1_		
ķ.	22 0	<u>.</u>	Sequentially list conditions, if any leading to immediate b. Hyperglycemic Epi	Isode		
	rted nsit	min	cause. Enter Underlying Cause (Disease or injury			
Ć,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):			
8760,	icate be executed physician and s the burial-transit	dical	d			
9	rtifica ng ph as th	Med	IF FEMALE:			
Вох	eath certific attending p for use as	an/I	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pr pregnancy  1 Live birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of delivery  Month Day Year
0	e des the at red fo	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5	Other (specify)	-	
<u>α</u>	ires that the de signed by the a I be detached f		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute to the cause of death?
ds,	requires that the death certific neen signed by the attending p hould be detached for use as	dby	_		1 □ Y	es 2 No 3 Probably 4x⊠Unknown
COL	w requir been si should	Completed			24a. Was a	an 24b. Were autopsy findings available
Re		mp			autop: perfor	med? death?
ā			25. Was case referred to medical	26. Place of Dea	1□ Yes ath (Check only or	-12
or Vital Records,	Physicien: The le ruith the certificete has ral director, page 2	To Be	examiner? 1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie	Other		ence 6 X Other (Specify) Hospice
0	- E		27. Manner of Death 28a. Date of Injury 28b. Time			ow injury occurred
io	Attending r death. ector: After by the fune	atio	2 Accident investigation	M 1 Yes 2 No		
Division	or Attendatter death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (S City or Tow	treet and Number or Rural Route Number, n, State)
	oltal or urs afte erel Dir		29a. Certifier 1 X CertifyIng Physician: To the best of my knowledge, dea	ath occurred at the time, date and place	and due to the	cause(s) and manner as stated
/	Hospital 24 hours a Funerel I	edical	29a. Certifier  (Check only)  One)  Check only)  Medical Examiner: On the basis of examination and/or in and marner stated.	investigation, in my opinion, death occ	urred at the time,	date and place, and due to the cause(s)
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Mec	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Month, Day, Year)
			I grewer / ho ( )	D0064615		January 10, 2008
	4		30. Name and address of person who completed cause of death (Item 23a) (Type			
			Genevieve Wroblewski 6001 Muncaste		le, MD	
	Sta Regist		31. Date filed (Month, Day, Year)  1AN 1 5 2008  32. Registrar's Signature	e e		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 19, 2008 3:50 P<sub>M</sub> Laura May Greenwell /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** St. Mary's Nursing Center Leonardtown St. Mary's 8. Date of Birth (Month, Day, Year) Pebruary 3, 1924 West Virginia Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 ☐ M 2 🖾 F Months Days 217-68-9448 83 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyghene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland St. Mary's California 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45531 Seven Gables Lane USA 20619 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3₺ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James W. Abshire Mary Angeline Street 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel A. Greenwell / Son 44704 Emma Lane Hollywood, MD 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State January 23, Charles Memorial Gardens Leonardtown, Maryland 4 Donation 5 Other (Specify) 2008 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi bleed and Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 200 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 47066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avani D. Shah, M.D. 22650 Cedar Lane Court Leonardtown, MD 20650 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 2 2008 Registrar

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			Please 1	Otata of Manua				-		gible.		
			1 - For State	State of Maryla		ertificate of L				008	023	334
			Registrar  1. Decedent's Name (First, Middle, Last)			initiate of L	Jean	2. Date of Dea	eg. No		3. Time of	Death
	Physici		1	re Gli	ck			Month	Day	OS Year	l	AM
	/Medic Examir		4a. Facility Name (If not institution, give si			4b. City, Town, or	Location of Death	•		unty of Death	4	
			Glade Valley Nurs	ing and Re	hab	Walke	ersuille	_		re der		
	Funeral		5. Social Security Number 6. Sex		rs. last birthday	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthp Coun	lace (State o	r Foreign
	Director		311341132	W 2941	79 Yrs.	1		12/17/1	928_	Wash	ingtor	ı, D.C
	and and		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or I	ocation				1	0d. Inside Ci	ty Limits
	Mary Fied	ţō	MD Montgomen	ry Ga	ithers	burg					1 🏹 Yes	2 🗌 No
	or 28e	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen	of What Coun	itry?	
	th wit	aiD	18722-4 Walkers (	Choice Rd.		20879			U.S.			
	r dea	ne	11. Marital Status	<ol><li>Was Decedent Ever in Armed Forces?</li></ol>	U.S. 13	. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spon, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,		
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Sp	ec <i>ity:</i> Whi	t o	
8	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or items 23e or 28e-f show event, the Medical Examiner must be mailied at	ed	15. Decedent's Educ	ation	16a. Dec	edent's Usual Occupa	ation		16b. Kind	of Business/Inc		
215	ar n	plet	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Giv life.	e kind of work done of DO NOT use retired	luring most of work. )	ing				
21,	giene er the	Completed	12	2	Offi	ce Manager				istrat	ive	
nd	be filed tal Hygi d other event, I	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Sui	тате)		
yla	2 should be filed withlr and Mental Hygiene. Is marked other than aumatic event, the Ma	၉	Maurice Bresnahar				Thelma		O': T	C: - T	0.41	
Maryland 21215-0036	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Typ			ling Address (Street a			-			
	1 and Health em 27 ther tr		Lisa Olson, Daughte 20a. Method of Disposition			8 Gambrill  cosition (Name of ematory or other place				ion - City or To		
٥	Pages nent of I int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	annovan nom State		ematory or other place coln Cemet		2/2008	Brent	wood, I	MD.	
Baltimore,	글 돈 돈 줄 .		21. Signature of Funeral Service License			22. Name and Addres	-	1/2000		9 Balt		Ave.
ä	Depa Depa Impo any i		Claudetto	Darch	G	asch's Fun	eral Home	e, P.A.	Нуа	ttsvi <u>l</u>	le, MI	2078
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the de e cause on each line.	eath. Do not e	nter the mode of dying	g, such as cardiac	or respiratory arr	est,		Approximat Interval Bet	ween
1	Physician		Immediate Cause (Final disease or condition	5tro							Onset and	~th
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):							
	Lxammer	<u>.</u>	Sequentially list conditions, b.	Due to (or as a cons	equence of):							
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or if july that initiated events	200 10 101 20 2 00110	oquo:100 01).					6		
<u>,</u>	le be executed ysician and e burial-transit	Examiner	resulting in death) Last	Due to (or as a cons	equence of):							
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89	Physician: The law requires that the death certifical this certificate has been signed by the attending phyral director, page 2 should be detached for use as the	Jedi	IF FEMALE:				_					
Box	ath ce ttendii	an/	23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F	etal death 3	□Ectopic pregnancy			23d	Date of delive	-	Year
	the all	Physician/Medi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown	f death 5	Other (specify)					,	
P.O.	that the de led by the a detached i		Part II. Other significant conditions cont	tributing to death but not	esulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use	contribute to the	ne cause of o	death?
of Vital Records,	uires tha signed Id be del	d by		-		, -		1 □ Y	es 28K	lo 3□Prob	ably 4 🗆	Unknown
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u o	Ing PI		27. Manner of Death 1 ☐Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time Injury	Work	c?	28d. Describe h	ow injury o	ccurred		
sio	uttendir death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	and Olever of Leiters A	\ h - m - 4		Yes 2 □ No	28f. Location (S	treet and N	lumber or Rum	I Route Nua	nher
Division	or At after of Direction by	Certification;	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	cify)	street, ractory, onice		City or Tow		ambor or riare	11 710015 74077	1201,
_	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the tuneral director, page		29a. Certifier 1 Certifying Phys	ician: To the best of my i	nowledge, de	ath occurred at the tim	ne, date and place,	and due to the o	ause(s) an	d manner as s	tated.	
	ne Ho	Medical	(Check only 2 Medical Examin one)	er: On the basis of exam and manner stated.	ination and/or	investigation, in my op	oinion, death occur	red at the time, o	late and pla	ace, and due to	the cause(s	5)
	To the within To the Comp	Me	29b. Signature and title of certifier	1		29c. License				igned (Month,		
)	(B)		Michael	Lerner	Mo	D41	619		den	ary 1/	, 20	08
	Com		30. Name and address of person who con								MD 03	700
	) W		Michael A. Lerne 31. Date filed (Month, Day, Year)	er, MD 6		as Johnson	Drive,	Suite E,	Fred	lerick,	MD 21	.702
	Sta Registi		JAN 1 5 2008	32. Hegistrar's Sk								
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AMEND TITEM 31 per DVR 0875 1/30/08 WS
State of Maryland Department of Health and Mental Hygiene 0 0 0

		1 - Stata Registrar		Ce	rtificate (	of Death	· · · · · · · · · · · · · · · · · · ·	Reg. No.	0 02333	
Physicia	an	Decedent's Name (First, Middle, La.  Porman	_		Hix	on	2. Date of De	ath y 27, 200	3. Time of Death 2:30 pm M	
/Medic Examin	al	Berman  4a. Facility Name (If not institution, given 3336 Deneen Road		<del></del>	,	n, or Location of [		4c. County of Washir	Death	
Funeral Director		5. Social Security Number 6. S	ex 7. Age (	In yrs. last birthday,			Hrs. 8. Date of Bi	th year) 9	Birthplace (State or Foreign Lary Land	
Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Washing		oc. City, Town or L Hancoc					10d. Inside City Limits 1 ☐ Yes ※XXNo	
h with the	al Director	10e. Street and Number 3336 Deneen Ro	pad		10f. Zip Coo 21	<sup>de</sup> 750		10g. Citizen of What U.S.	•	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Midowed 4 Divorced	12. Was Decedent Eve Armed Forces? XXYes 2 □ No 11Yes, Give Year or Dates:	er in U.S. 13.	Was Decedent If Yes, specify ( 1 ☐ Yes XX	Cuban, Mexican, P	? (Specify Yes or No Puerto Rican, etc.)		American Indian, White, etc. White	
d 2 should be filed within 72 hours aft than Mental Hygiene. ?? is marked other than "natural", or traumatic event, the Medical Examm	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	DO NOT use re	one durina most oi	f working	16b. Kind of Busin		
ould be titled Mental Hyg arked other attic event,	To Be C	17. Father's Name (First, Middle, Last)	erman	Hixo	n	18. Mother's	Name (First, Middle Jes	, Maiden Sumame) ssaline	Effland	
and 2 should I ealth and Meni n 27 is marke		19a. Informant's Name/Relationship ( Darl Lee Hixon	Type, Print)				Needmore,			
permit. Pages 1 ar Department of Hea mportant: If Item in Injury or other		20a. Method of Disposition  1	Removal from State	20b. Place of Dispo cometery, cre St. Thoma	matory or other	nlace)	Date /25/2008	20c. Location - Cit Hancock,		
permit. Departri Importa any inju		21. Signature of Funeral Service Licer					Funeral Horkeley Spr		25411	
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ath c ttend or us	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							23d. Date of delivery Month Day Year	
quires that the densigned by the a	þ	Part II. Other significant conditions o	ontributing to death but r	not resulting in the u	inderlying cause	given in Part I.	23e. Did 1	V	icco use contribute to the cause of death?	
The law ate has b page 2 sl	Completed						24a. Was auto perio 1 🗆 Yes	prio prio dea	r to completion of cause of th?  Yes 2 No	
Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Death (Check only o		Z - //	
<u> </u>	2	1 ☐ Yes 2 XX Yo  27. Manner of Death	28a. Date of Injury	2 ☐ ER/Outpatier 28b. Time o	nt 3 DOA	niurv at	ng Home XX Resi	dence 6 □Other ( how injury occurred	(Specify)	
Attending is death. ector: After by the fune	it lo	1 XXatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	ear) Injury		njuryat Work? I∐Yes 2∐No				
To the Hospital or Attending PP within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, sti Specify)	reet, factory, offi	се	28f. Location ( City or To		or Rural Route Number,	
ne Hospit n 24 hours ne Funera	ledical (	29a. Certifier 1XXertifying Ph (Check only one)	ysician: To the best of m iner: On the basis of ex and manner stated	amination and/or in	h occurred at th vestigation, in n	e time, date and p ny opinion, death o	lace, and due to the occurred at the time,	cause(s) and manne date and place, and	er as stated. I due to the cause(s)	
	W	29b. Signature and title of certifier	Halm MD		D5	6048		29d. Date signed (A January 2		
1841		30. Name and address of person who a Matthew A. Hahn				ancock N	∕D 21750			
Stat Registra		Matthew A. Hahn, 31. Date filed (Month, Day, Year)  Tanutry 13, 2008	32. Registrar's ► IAN	Signature 3 0 2008	E.	ligt.	L 21730			
HMH 17 Rev 1/20		January NJ 2008	7678 88 8		5	18			7.5533153	

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 → No Nown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or within 24 hours af To the Funeral D Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) re 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

10:00A M

Birthplace (State or Foreign
Country)

Black, White, etc.

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month  $P^{M}$ Edward Gaspard Henley, Sr. January 2008 /Medical 1818 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 336 Hollingsworth Manor Ceci1 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 25, 1923 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1**X** M 2□ F 223-24-0162 Director 84 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show must be notified at 1 X Yes 2 ☐ No Director Maryland Ceci1 E1kton or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 336 Hollingsworth Manor 21921 United States death 1 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1945-1 M Yes 2 □ No If Yes, Give Year or Dates: 1947 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 💢 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Hydraulics Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Fulton Henley Mary Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Robert L. Henley/Son Jensen Lane, Elkton, MD 21921 Baltimore, 20b. Place of Disposition (Name of Gilpin Manor Memorial Park permit. Pages 1 a Department of Hea Important: If item 20a, Method of Disposition Date 20c. Location - City or Town, State January 25 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Elkton, MD Signature of Funeral Service License 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, MD 21921 23a. Part1. Env r the disease, or conshock or heart failure. List or cation that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one pluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician emer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 ☐Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 \( \text{Nursing Home} \) 1 ☐ Yes 2 ☑ No ၉ 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours are To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Manth, Day, Year)

State Registrar

541

0040

Name and address of person who completed cause of death (Item 23a) (Type, Print);

Dimonson

JAN 3 0

31. Date filed (Month, Day, Year)

MD

11/20.

32 Registrar's Signature

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o e r than "natural", or items 23a the Medical Examiner must b

3altimore, Maryland 21215-0036

**Physician** /Medical Examiner

Division or Vital Records, P.O. Box 68760.

ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After

State of Maryland / Department of Health and Mental Hygiene 02338 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Mildred 5:00 P M Elizabeth 21, January 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Center Clinton Prince George's If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗓 F Director 216-24-8689 Maryland 80 Dec 24, 1927 Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a anal Injury or other traumatic event, the Medical Examiner must once. 15701 Mt. Calvert Road 20772 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 2 Specify: 3 X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 office manager, processor <u>farm credit</u> bureau 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter William Sherbert Iva Marie Walton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis C. Hook, 51 Greenfield Lane, Huntingtown, MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Thomas' Parish 01-26-2008 Croom, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. K 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complication. hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gastric Voluvius with pertovation < 72 hours disease or condition resulting in death) Due to (or as a consequence of): 1997 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner with hypertension Due to (or as a consequence of): herm ata Physician/Medical > 10 years IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 250 Phagives 122 Me 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 **X**No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D042049 22,2008 Jamary Name and address of person who completed cause of death (Item 23a) (Type, Print) Lain G. CHAMPALOUX MD U 15 Upper Marlboro- MD. 20772 31. Date filed (Month, Day, Year) State Registra DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Clyde Eugene Homan, Jr. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbur Hospice at the 100MICC ake If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 8/15/1950 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1**X**] M 2□ F 57 231-72-5182 Director **Alaska** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10h Counts 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 X No Director Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44 Boston Dr. 21811 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Completed by 3 Widowed 4 Divorced White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Retail marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) in and Mental h Be Clyde E. Homan, Sr. ပ Beula Jane Weber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is Lucinda Homan / wife 44 Boston Dr., Berlin, MD 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of I-Important: If ite any injury or ot 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Cape Henlopen Crem. 1/15/2008 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 mla Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ARCINOMA disease or condition resulting in death) /Madical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Attending Physician: The law requires that the death certificate be executed use as the burial-trar and Due to (or as a consequence of) attending physician by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 □ Yes 2 No Completed peen 24a. Was an has autopsy 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

Division or Vital Records, P.O. Box 68760, сотрете filled in by the funeral director, To the Hospital within 24 hours a To the Funeral I

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) Registrar

CHumon

JAN 1 6 2008

WAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COASTAL HOSPICE 32. Registrar's Signature

2005 8410

P.O BOX 1737 SAVISBURY UP 21207

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

32. Registrar's Signature

JAN 1 6 2008

Division or Vital Records, P.O. Box 68760.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Physicia /Medica Examine **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

	1 - State Registrar	Certificate of Death Reg. No.	2008 02341								
	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day	3. Time of Death								
	Frank Inomas Ho	Dans Jan 10	2008 0013								
7	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c.	County of Death								
	Chester Kiver Mospital	Center Chestertown MD K	ent County								
	214-22-8271 1™ 2□ F	8. Date of Birth (Month, Day, Year)  1 (In yrs. last birthday)  2 (In yrs. last birthday)  2 (In yrs. last birthday)  2 (In yrs.	9. Birthplace (State or Foreign Country) MD								
	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits								
5	MD KENT	CHESTERTOWN	1 Ty Yes 2 No								
נ	10e. Street and Number		izen of What Country?								
5											
2	11. Marital Status 12. Was Decedent E		SA 14. Race - American Indian,								
3	Armed Forces?  1 □ Never Married 2 ▼ Married 1 ▼ Yes 2 □ N  If Yes, Give	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.								
Š	3 ☐ Widowed 4 ☐ Divorced	UWII 1 Yes 2 No Specify:	Specify: WHITE								
2	15. Decedent's Education	16a. Decedent's Usual Occupation 16b. Ki	ind of Business/Industry								
2	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5-	(Give kind of work done during most of working life. DO NOT use retired)									
5	12 5+	· 1 1	ALTHCARE								
2	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden	Surname)								
5	HASTINGS B. HOPKINS	ELLA STONESTREET	Γ								
	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rural Route Number, City o	r Town, State, Zip Code)								
	GRACE HOPKINS/WIFE	329 HERON POINT CHESTERTOWN, MD 2	21620								
	20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place)  Date  20c. Lo	ocation - City or Town, State								
	4 □ Donation 5 □ Other (Specify)	CHESAPEAKE CREMATION 1/11/2008 STEV	VENSVILLE, MD								
	21. Signature of Funeral Service Licensee	. FELLOWS, HELFENBEIN & NEWNAM I									
	Kick J. Helfenle	130 SPEER RD. CHESTERTOWN, MD	21620								
	23a. Part1. Inter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e.	Approximate Interval Between								
	Immediate Cause (Final disease or condition		Onset and Death								
	resulting in death)	a consequence of):	10 ///								
	Sequentially list conditions b. STAPH HUREUS CELLULITIS										
2	Sequentiary list conditions,  Luc to (or as a consequence of):  cause. Enter Underlying										
0	that initiated events c.										
Ĺ	resulting in death) Last Due to (or as a	a consequence of):									
2	d	d									
	IF FEMALE:		!								
2	23b. Was decedent pregnant in the past 12 months?	2 ☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date of defivery  Month Day Year								
3	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 9 ☐ Unknown	time of death 5 Other (specify)									
	Part II. Other significant conditions contributing to death but	t not resulting in the underlying cause given in Part I 23a Did tobacco u	use contribute to the cause of death?								
2		the second of th	No 3 Probably 4 Unknown								
2	WE WINDOW WE WILL THE WAY										
2		24a. Was an autopsy porformed?	24b. Were autopsy findings available prior to completion of cause of death?								
5		performed? 1  Yes 2 No									
3	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death (Check only one)  Other: Other: The state of Death (Check only one)									
2	1 ☐ Yes 21 No Hospital: 11 Inpatie  27. Manner of Death 28a. Date of Injur	11 2 Envolupation 3 DOA 4 Nursing Home 5 Residence									
5	1 Natural 5 Pending (Month, Day 2 Accident investigation	y Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injur Work? 1	y occurred								
5	3 Suicide 6 Could not be 290 Place of inju		nd Number or Rural Route Number,								
	4 Homicide determined building, etc	(Specify) City or Town, State	e)								
5	29a. Certifier 1 Certifying Physician: To the best of	of my knowledge, death occurred at the time, date and place, and due to the cause(s)	) and manner as stated								
3	(Check only 2 Medical Examiner: On the basis of one)	examination and/or investigation, in my opinion, death occurred at the time, date and	d place, and due to the cause(s)								
2	29b. Signature and title of certifier	29c. License number 29d. Dat	te signed (Month, Day, Year)								
	> HULL A MATER.	MD D0041578 11	110/2008								
	30. Name and address of person who completed cause of de	100-100-11-010									
	· · · · · · · · · · · · · · · · · · ·										

State of Maryland / Department of Health and Mental Hygiene

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after deatl To the Funeral Director:

Physician /Medical Examiner

> State Registrar

JAN 1 4 2008

122

31. Date filed (Month, Day, Year)

Speer 4Rd



**Physician** /Medical Examiner

Director filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f show dical Examiner must be notified at

Baltimore, Maryland 21215-0036

and Mental Hygin

**Physician** /Medical Examiner

attending physician and for use as the burial-transit The law requires that the death certificate be executed the cate has been signed by page 2 should be detack certificate or Attending Physician: director, the funeral After after death. filled in by within 24 hours a

To the Funeral I Hospital completely

Division or Vital Records, P.O. Box 68760,

2. Date of Death 1. Decedent's Name (First, Middle, Last) January 13, 10:35 A M James Harold Herbert, Sr. 200<sup>Yea</sup> 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Days **Funeral** Hours Months 1X M 2 □ F 72 January 27, 1935 Maryland 577-46-9326 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2X No Maryland St. Mary's Lexington Park Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 46408 Chapman Drive 20653 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 No ò 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Gravel Company College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Item 27 Is marked other It any Injury or other traumatic event, the once. 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nick Parker Mary Agnes Herbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James Harold Herbert, Jr. / Son Chaptico, MD 20621 P.O. Box 351 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 17, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bushwood, Maryland Sacred Heart Cemetery 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Mattingley-Gardiner Funeral Home, P. P.O. Box 270 Leonardtown, MD 20650 Approximate Interval Between Onset and Death 23a. Pa v. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Year Dav Month in the past 12 months? 5 ☐ Other (specify) 1□Yes 2⊡No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 🗆 No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 @ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of James P. Jarboe, M.D. person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 24035 Three Notch Road Mollywood, MD 20636 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JAN 16 2008

Division or Vital Records, P.O. Box 68760,

State

31. Date filed (Month, Day, Year)

JAN 1 5 2008

29b. Signature and title of certifier

ho 1 mm

Eric McDowald and 7503 Surratts RD Clinton, Md 20735 32. Registrar's Signature

30. Name and address of person who complet id cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 29c. License number

D0064055 01/05/08

29d. Date signed (Month, Day, Year)

08-00569	
Ronald Holloway	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ronald Holloway		State of Maryland / Department of Health and Mental H 1- For State Registrar.  Certificate of Death		Reg. No.	200	8 0234
Physicia	n/	Decedent's Name (First, Middle,Last)	2. Date of De	eath	Year	3. Time of Death
Medical Examir	ler	RONALD HOLLOWAY  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Deal	January	20, 2008	County of Death	1143 hrs
		4208 Plumbers Promise Drive Bowie			nce George	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hi			Foreig	thplace (State or
Director		204-21-24/0 1X M 2 F 32 Yrs.	11/09	/1955	Co	untry) FLORDIA
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
<u> </u>	5	MD PRINCE GEORGES BOWIE				1 XX Yes 2 No
the Maryland 23a or 28a-f sho notified at once.	rect	10e. Street and Number 10f. Zip Code		10g. Citizer	n of What Cou	ntry?
in 148		4208 PLUMMERS PROMISE DRIVE 20720		USA		
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		No- 14	4. Race - Ameri White, etc.	can Indian, Black,
hours after "natural", Examiner	à	4 Divorced of Power 1986-2001 1 Yes 2 X No specify:	adi dana		pecify: BLAC	
7 3	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	tired)		nd of Business/	naustry
5-0036 led within 72 Hygiene other than the Medical	립	5+ CHIEF OF DEPARTMENT OF	DEFENS	E GOV	ERNMENT	
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than " event, the Medical	Be Co				ırname)	
T. 2 8 8 5	70 B	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or	COLLIN		or Town, State	. Zip Code)
AC 2 st 2 st 27 in an an an an an an an an an an an an an		ROSALIND HOLLOWAY/WIFE 4208 PLUMMERS PROMIS	E DR. B	OWIE,	MD 207	20
ore, Nes 1 and of Health	1	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Lo	cation - City or	Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If itel injury or other tr		4 Donation 5 Other Specify: RIVERDALE CREMATORY 01	/28/200	8 RI	VERDALE	, MD
Bal permi Depar Impo injur	-	21. Signature of Funeral Service Licensee  22. Name and Address of Facility J., 7474 LANDOVER ROAL				
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory a	rrest, shock	, or heart	Approximate Interval
/Medical xaminer		Immediate Cause (Final disease a AS hyxia				Between Onset and Death
		or condition resulting in death)  Due to (or as a consequence of):				
	힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
git q	Examiner	C. Due to (or as a consequence of):				
6 be executed sysician and burial - transi	<u>8</u>	d.				
60, te be e nysicia e burial	Medical	IF FEMALE:  AMENDED #23a.27.28a-f. perME.g877 3/10/08 TT  23c. If yes, outcome of pregnancy		1 224 1	Date of deliver	
687 ertifica ding pl	an	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregr	iancy		Date of delivery Ionth [	Day Year
Box 6876( The death certificate the attending physed for use as the b	Physician/M	4 Pregnant at time of death 5 Other (Specify)   1 Yes 2 No 9 Unknown g Unknown		- 10		
P.O. Es that the gned by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
rds, P.O.	ed by		1Y			pably 4 🗸 Unknown
ord aw req has bee	Completed			s an opsy formed?	24b. Were au prior to d death?	topsy findings available completion of cause of
tal Reco			1 🗸 Yes	2 No	1 ✓ Ye	es 2 No
Division of Vital Records, tal or Attending Physician: The law requirer stander death.  al Director: After this certificate has been si and the function of th	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  26. Place of Death (Check to be determined)  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other, Nursi	na Home 5	Residenc	ce 6 🗸 Other	: Scene
ing Ph	-1	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describ			
Sion Attend or death ector: by the f	딅	1 Natural 5 Pending 2 Accident Fnd 1/20/2008 unk 1 Yes 2 X No	unk			
Divis	ertification:	3 Suicide 6 X Could not be determined (Specify) Specify Home	28f. Location	(Street and State)	Number or Ru	Dr. Bowie, MD
hou hou	ا د	4 Homicide (Specify) FIQURE  29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an				
To the Hos within 24 h To the Fur		one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.				
- ' '	Σ .	29b. Signature and title of certifier  29c. License number			ite signed (Moi	
	-	30. Name and address of person who completed cause of death (Item 23a)		Janua	ary 21, 2008	,
R		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	201			
Sta Registra	te i	31. Date filed (Month, Day, Year)  JAN 2 5 2008  32. Registrar's Signature				
DHMH 17 Rev 1/200	_	OPIONA				
OCME 2006		OCME				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23, 2008 **Physician** Mary Louise Jones 1655 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6987 Arbor Drive Frederick Frederick 5. Social Security Number 286–16–5997 8. Date of Birth July 20, Year) 920 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 87 1 □ M 2 □ F 6hib Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov must be notified at Maryland Frederick Frederick 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 6987 Arbor Drive . 23a 21703 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes XXNo
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married 1 □ YesXX No o, Baltimore, Maryland 21215-0036 þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Purchaser Department Store permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked oth any Injuy or other traumatic event one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald Kinkead Beatrice Unknown ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest P. Jones, Jr., husband 6987 Arbor Drive, Frederick, MD 21703 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory Jan. 25, 2008 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Keeney and Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of us yin each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 6 miles /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner spital or Attending Physician: The law requires that the death certificate be executed usurs after death.

usur after death.

leral Director: After this certificate has been signed by the attending physician and filled in by the fumeral director, page 2 should be detached for use as the bursar-transit filled in by the fumeral director, page 2 should be detached for use as the bursar-transit. Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □Ectopic pregnancy Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 1☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Di Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) January 24, 2008 030395 30. Name and address of person who completed cause of death 15 m 23a) (Type, Print) William H. Convey, M.D., 195 Thomas Johnson Drive, Frederick, MD 21702

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 3 0

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM/19a,b, 20b, per EH, C875, 1/30/08, VS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Adrian C. Jones 2008 5:30 P 24 Jan. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frost Village Nursing Home Frostburg Allegany 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Mar. 3, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months West Virginia 1923 234-26-5758 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event the Market. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No MD Allegany LaVale Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 103 Forest Drive 21502 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 TXYes 2 No 1943 If Yes, Give Year or Dates: 1946 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Bank Examiner Banking 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert C. Jones Martha (Bolton) Jones ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4716 Trotting In., Annandale, VA 22003 Douglas H. Jones -Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 01/27/08 Cumberland, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hafer Funeral Service, P.A. 21. Signature of Funeral Service Licensee ohn 1302 National Hwy., LaVale, MD Approximate Interval Between Onset and Death 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Advanced Comenthy /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of Examiner If any leading to him soft cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last g physician and as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Syndrome Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2**5** No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 ☐ Pending investigation within 24 hours after control to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier monsochelin 00055325 MY Jan 25, 2008 0+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WONSOCK SHIN 925 BESHOP WALSH RD CUMBERLAND MD 21502 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Amend #1,PI,	25,28b,28f, pe	aryland / rME,g876	Depai Cert	rtment of H	ieaith a Death	and Ment	al Hygi Re	ene g. No.20	08	02347
	Physici	an	1. Decedent's Name (First, Mid	dle, Last) EMMA G	RACE JE	STER	11	_		ate of Death	n Day	Year	3. Time of Death
. Ar	/Medic		19mma	-		-	KSICK		-	nuary	_	008	0504AM
	Examin	er	4a. Facility Name (If not institute	10 11 V	· Has	2/1	4b. City, Town, or	11-		Cila	4c. County	of Death	
	Funeral	-	5. Social Security Number	1) 5 1-10 P.O. 1. 6. Sex _ 7. Ac	ge (In yrs. last	birthday)	If Under 1 Year	if Under 2	70 / e 24 Hrs. 8. Da	ate of Birth		9. Birth	place (State or Foreign
В	Director		219-67-5797	1□M 2 <b>X</b> F	4	Yrs.	Months Days	Hours	Min. (A	fonth, Day, 0/23/	2003	Cou	MD MD
	and w		Usual Residence of Decedent  10a. State 10b. Coun	hv.	10c. City, To	own or Loca	ation						10d. Inside City Limits
	death with the Maryland ims 23a or 28a-f show r must be notified at	or											1 XYes 2 No
	28a- notifi	Director	MD KE 10e. Street and Number	NT_	RUCK	HALI	10f. Zip Code			10	g. Citizen of	What Cou	ntry?
	h with 23a o		5995 LAWTON AV	Ŧ.			21661	l			US	A	
	ems :	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. W	as Decedent of Hi Yes, specify Cuba	ispanic Orig	gin? (Specify Y	es or No-		ce - Americk, White,	can Indian, etc.
36	s afte	by F≀	1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes, Give	No		□Yes 2 <b>X</b> No	Specify:			Specia	у: т.т.	ITTE
15-0036	be filed within 72 hours after death with the Marylar at all Hyglene.  And Hyglene.  A		15. Decede	ent's Education	16	a. Decede	ent's Usual Occupa	ation		Ī 1	6b. Kind of B		dustry
215	thin 72 e. an "na Medii	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed) College (1-4or	5+)	(Give k. life. Di	ind of work done o O NOT use retired	during most d)	t of working				
21	ed wir ygien ner th t, the		0			NON	NE T				NONE		
Maryland 21		Be	17. Father's Name (First, Middl						er's Name (Firs			ne)	
Š	d 2 should th and Men 7 Is marke traumatic	욘	JOHN F. JES 19a. Informant's Name/Relation		1:	9b. Mailing	Address (Street a		NIFER_L er or Rural Rou			State, Zir	Code)
_	tra		JENNIFER L. E	-		_	X 107 RC				_		,
Ze,	一工をき		20a. Method of Disposition		20b. Place	of Disposi	ition (Name of atory or other plac	- :	Date		20c. Location	- City or T	own, State
Ĕ	D 0		4 Donation 5 Other	a 3 □ Removal from State (Specify)	WESLE	Y CHA	APEL	1	1/12/20	08 R	OCK HA	LL, M	ID .
Baltimore,	permit. Pag Department Important: any Injury once.		21. Signature of Funeral Service	e Licensee Allestei	$\supset$	FEI	Name and Addres LLOWS, HE SPEER F	ELFENÉ	BEIN &	NEWNA	M FUNE	RAL E	IOME, PA
	S-0.94		23a. Part1. Enter the disease,	or complications that causes st only one cause on each li	d the death. D							20	Approximate Interval Between
9	Physician		Immediate Cause (Final disease or condition	1	vmat	50	brain	in	IUNU				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	ce of):	/	J					91
		<u>-</u>	Sequentially list conditions, if any leading to immediate	b. Sp.	a consequenc	e of):	a inj	vry			all	7	11045
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1 mot	W i	sehi	ide a	Coi	dent MFICATION APP	Mar	-WORLE AM	NER	9hours
oʻ	ificate be executed g physician and as the burial-transit	Еха	resulting in death) Last	Due to (or as	a consequenc	e of):	011		TON APP	ROVEDBYN	Ello		
98/89	ate be hysicii he bu	edical		d				CERT	TIFICATION	/			
		Mec	IF FEMALE:	220 If you system to								'	===
Rox	law requires that the death certificate been signed by the attending to should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant a	2 Fetal dea		Ectopic pregnancy Other (specify)	1				ite of deliv onth	ery Day Year
o.	the d	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□Unknown	t time of dodin	00	Cition (apcony)						
ώ.	w requires that the d been signed by the should be detached	by Pi	Part II. Other significant condi	tions contributing to death b	out not resulting	g in the und	derlying cause give	en in Part I.	. 2	3e. Did tob	acco use con	tribute to t	he cause of death?
ğ	en sig									1 □ Ye	s 2 1 No	3 Pro	bably 4 □Unknown
Hecords,	law re as be 2 sho	Completed							2	4a. Was an		Were auto	opsy findings available impletion of cause of
	: The law cate has page 2 s	Con							1	perform ☐ Yes 2	ned?	death?	2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medic examiner?	Hospital:			2 DOA Othe	er.	of Death (Che				
ō	ži iši ji	5	1 X Yes 2 4	28a. Date of Inju			3 DOA	4 L Nu!	rsing Home !		nce 6 Dot		fy)
0	nding F th. r: After e funera	Certification:	1 Natural 5 Pend 2 Accident inves	ling (Month, Da itigation January 3,		D. Time of Injury 8	28c. Injury Work	k? Yes 2.12∏11	<i>ر</i> ا ر	oter			cident
Division	r Atter	tifica	3 ☐ Suicide 6 ☐ Coul- 4 ☐ Homicide deter	a not be 28e. Place of ini			et, factory, office		28f. Lo	ocation (Str	eet and Num. State) <b>D</b>	per or Run	al Route Number,
5	ital or irs afte ral Di	Cer			St	rect			For	the Zo	at Mai	Tin M	togner Road
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier  (Check only one)	ring Physician: To the best al Examiner: On the basis of and manner st	of examination	ige, death and/or inve	occurred at the tin estigation, in my o	ne, date and opinion, dea	nd place, and d ath occurred at	ue to the ca the time, da	use(s) and mate and place	anner as s and due t	stated. to the cause(s)
	Vithi To ti	ž	29b. Signature and title of certif	ier/ Lann	111	`	29c. License	, _		29	d. Date signe	ed (Month,	Day, Year)
)			· (uu)	MILLE	MI	)	D00	663	551		Janva	inj "	7, 2000
_			30. Name and address of person	HAS MD	600	Novi	n wote	Stre	ect	Bathr	nore 1	Janj	t, 2008 Jund 21287
	Sta Registr		31. Date filed Month, Day, Yea		rar's Signature	* A	South						
			V/III		- T	- PAGE							

DHMH 17 Rev 1/2001

State

Registrar

2008

JAN 1

Johnson

4b. City, Town, or Location of Death

Charlotte Hall If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 2. Date of Death

8. Date of Birth (Month, Day, Year)

June 5, 1951

Month

Day

4c. County of Death

St. Mary's

January 15, 2008

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2X No

Pennsylvania

12:15p M

Dalimiele, mai yiang 21213-0030
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
importent: If item 27 is marked other than "natural", or itame 23a or 28a-f show
any injury or other traumatic event, the Mudical Examinary tast be notified at

**Physician** 

/Medical

Examiner

**Funeral** 

Director

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

10a. State

226-76-0046

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

10b. County

Charlotte Hall Veterans Home

6. Sex

MOKM 2□F

Raymond

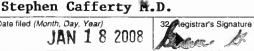
7. Age (In yrs. last birthday)

10c. City, Town or Location

56

	e 23a or 28a-f sh	ctor	Maryland St. Mai	v's	Charlo	tte Ha	all				1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number			10f. Zip			10g. Citizen	of What Co	untry?
	th wil	al	29449 Charlotte	Hall Road			20622		U	SA	
030	a within 72 hours after death with the Man jiene rthan "natural", or itame 23a or 28a-f sh Lie Madical Examinar rush be notified	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 🏝 Divorced	12. Was Decedent Ever in I Armed Forces? 1 <b>弦</b> Yes 2 ☐ No If Yes, Give Year or Dates:	U.S. 13.	Was Deced If Yes, spec	ent of Hispanic Origin? ( Ify Cuban, Mexican, Pue  In No Specify:	(Specify Yes or Nearto Rican, etc.)		Race - Ame Black, White ecify:	
215-0036	within 72 ho ene. than "naturi	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	edent's Usua e kind of won DO NOT us	l Occupation k done during most of w e retired)	rorking		f Business/l	,
Z	filed w Hygier Sther th	ပိ	12			Carpe			4	struc	tion
yiand	0 m = >	Be	17. Father's Name (First, Middle, Last)	T.1.			_	ame <i>(First, Middle</i> <b>Eliza</b> l			omery
	es 1 and 2 should be of Health and Ment I Item 27 Is marked recting the traumatic en	2	Lester Wilhe		-1		Grace				
Mar	12 st h and 7 te n traun		19a. Informant's Name/Relationship (7			_	(Street and Number or I				
e,	l and lealt		Lois J. Ciampo/ S 20a. Method of Disposition		Place of Disp		ingston Rd.	Date Date		on - City or	
Банттог	y o		1 Burial 2 Scremation 3 4 Donation 5 Other (Specify	Removal from State	cemetery, cre	imatory or ot	nols Cr 1/1				Iall, MD
gall	permit. P Departme importer any injur		21. Signature of Funeral Service Lice	M0081	17 E	2. Name and Tinsf	Address of Facility ield-Echols Three Notch	Funeral Rd., Ch	Home, arlott	P.A.	L, MD 20622
			23a. Parti. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	ath. Do not er	iter the mode	of dying, such as cardi	ac or respiratory a			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Chronic Ob		ive L	ıng Disease				
	Examiner			Umertensi							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Hyper Lens I							
	cuted nd ransi	Examin	Cause (Disease or injury that initiated events	c Diabetes M	Mellitu	ıs					
Ď,	e exe		resulting in death) Last	Due to (or as a conse							
08/00	icate be executed physicien and s the burial-transit	dica		d. Coronary A	Artery	Diseas	se				
O. Box 6	res that the death certificate be executed signed by the attending physicien and be detached for use as the buriat-transit	by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	tal death 3	⊒Ectopic pre ☐ Other (spe				Date of deli Month	very Day Year
Ž	s that med t	y P	Part II. Other significant conditions of	ontributing to death but not re	sulting in the t	underlying ca	iuse given in Part I.	23e. Did	tobacco use c	contribute to	the cause of death?
cords	w requires been sign should be		Lung Nodule					1 🗀	Yes 2□N	3 🗆 Pro	obably 4XUnknown
Heco	sician: The law re certificate has be- lirector, page 2 sho	Completed	Colon Polyps						ormed?	death?	topsy findings available completion of cause of
N Ea	sician: ] s certificat lirector, p	0	Multi Infarct I	<b>Ременста</b>			26 Place of D	1 ☐ Yes eath (Check only		1 L Yes	2□ No
>	ysici s cer direct	.o	examiner? 1 ☐ Yes 21KD No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3∏ DO	100	Home 5 ☐ Res		Other (Spec	eifv)
0 00	iding Ph th.: After thi funeral	tion: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		3c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe			,,
DIVISION	sepital or Attending Physi hours after death. Ineral Director: After this c y filled in by the funeral din	ertification:	3 Suicide 6 Could not be determined		home, farm, st	reet, factory,	office	28f. Location City or To	(Street and Nu wn, State)	umber or Ru	ral Route Number,
	To the Hospital or within 24 hours aft To the Funeral Discompletely filled in	edicai C	29a. Certifier (Check only one)  12 Certifying Ph 2 Medical Exam	ysician: To the best of my kn iner: On the basis of examin and manner stated.	nowledge, dea nation and/or in	th occurred anvestigation,	at the time, date and pla- in my opinion, death oc	ce, and due to the	cause(s) and date and place	manner as ce, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of gentiler	16		29c.	License number		29d. Date sig	gned (Monti	n, Dey, Year)
	- > - 0		> XXXIII	400		H	0037228		Janua	rv 15	, 2008
			30 Nam and ad ress of person who o	completed cause of death (Ite	m 23a) /Tuna				Janua		, 2000

State Registrar 31. Date filed (Month, Day, Year) JAN 1 8 2008





Charlotte Hall, MD 20622

For State Registrar	State of Maryland / Department  Certificate
1. Decedent's Name (First, Middle, Last)	

			1 - State Registrar	,	Cei	rtificate of	Death	F	Reg. No.		
¥			1. Decedent's Name (First, Middle, Las	st)		· · · · · · · · · · · · · · · · · · ·		2. Date of Dea	ath Day	Vaar	3. Time of Death
	Physicia /Medic		Barbara Ives	Judd				January		Year 2008	1:10 a <sup>M</sup>
	Examin	a	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death	1	4c. Coun	ty of Death	٦
		. 5	Taylor Farm Assis	ted Living		Bushwood				Mary'	's
	Funeral		Social Security Number     6. S	ex 7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	n /, Year)		nplace (State or Foreign untry)
L.	Director		019-03-2576	90	Yrs.			11/16/1	L917	Verr	nont
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	farylarylarylarylarylarylarylarylarylaryl	ō	,								1 □Yes 2 No
	the 1	Directo	Maryland St. Mary  10e. Street and Number	s St.	Inigo	10f. Zip Code			10g. Citizen of	f What Cou	intry?
	with a or			D 1							•
	leath	Funeral	17248 Gum Landing 11. Marital Status	12. Was Decedent Ever in U.S	S. 13.	20684 Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	United 14. Ra		rican Indian,
_	fter d r Iten iner	듄	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ∐Yes 2 X No		If Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)	BI	ack, White	e, etc.
3	hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	þ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1∐ Yes 2∭ No	Specify:		Spec	ify: Wh	ite
15-0036	be filed within 72 hours after death with the Marylan ital Hyglene.  Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Ec	lucation	16a. Dece	dent's Usual Occup	ation	kina	16b. Kind of	Business/I	ndustry
Z	filed within 72 Hygiene. hther than "nai	n p	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retired	d)	nurg			
7	ed wi ygien yer th	ပ်		2	Secre	tary			Educat		
and	be fill d oth even	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surna	ıme)	
$\equiv$	12 should be n and Mental r is marked o raumatic eve	은	Murray Ives		T		Elizabet				
Mar	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (	lype. Print)		ng Address (Street			, ,		
ტ ე	1 and Health em 27 ther tr		Craig I. Judd/Son  20a. Method of Disposition	20b. Pl		Vega Cou		ywood, I	1ary 1an 20c. Location		0636 Town State
وَ	tiges if it		1 X Burial 2 ☐ Cremation 3 ☐	Hemoval from State	emetery, cre	osition (Name of matory or other place					,
Baltimor	it. Part rtant rtant njury		4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Licer			endship ( 2. Name and Addre		2/2008 I			
g	permit. Pages 1 s Department of He Important: If item any injury or oth			M01206			DI				ome, P.A.
	与分		Kyle S. Simons  23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death		2955 Hold ter the mode of dying				/11 <b>,</b> MI	Approximate
	<b>D</b>		shock, or heart failure. List only Immediate Cause (Final					. ,	,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Respiratory  Due to (or as a consequ		re					Day
	Examiner			b. Congestive I		Failura					Week
li:	微	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ		Tarranc					WCCK
	the death certificate be executed y the attending physician and ched for use as the burial-transit	Examiner	that initiated events	c. Coronary Art	terv D	isease					Years
o Î	e exectant and and and and and and and and and and		resulting in death) Last	Due to (or as a consequ	ence of):						
08/80	tte be nysicia ne bu	Medical		d							
٥	rtifica ng ph	Med	IF FEMALE:								
õ	th ce tendi or use		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnated 1 ☐ Live birth 2 ☐ Fetal	ncy death 3[	∃Ectopic pregnanc	у			Date of deli Month	very Day Year
5	e dea the at	Sici	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5[	Other (specify)				nontin	Day
7	w requires that the death certific ben signed by the attending p should be detached for use as	Physician,	Part II. Other significant conditions of	ontributing to death but not resu	ilting in the u	nderlying cause giv	on in Part I	23e Did to	phaceo use co	ntribute to	the cause of death?
Š	The law requires that ate has been signed by bage 2 should be deta	by	Tartii. Other significant conditions	onabuting to doubt but not room	inting in the a	ndenying dadde giv	on mr arti.	1 🗆 1			obably 4 □Unknown
ecords,	requ	Completed									
é	e law has t	nple		·				24a. Was	an 24b	<ol> <li>Were au prior to death?</li> </ol>	topsy findings available completion of cause of
<u></u>		S						1□ Yes	rmed? 2 X No	1 ☐ Yes	2 No
VITal	Physician: The law this certificate has tral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		oth		ath (Check only o			Assisted
0	Phys this ral dii	_T	1 ☐ Yes 2 🕅 No 27. Manner of Death	28a. Date of Injury	ER/Outpatie	IL SEL DOA	4 I Nursing H	lome 5 ☐ Resid			city) Living Hom
	ding h. After funer	ion	1 X Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	rk? Yes 2 □ No	20d. Describe i	iow injury occi	uncu	
DIVISION	death death ctor: y the	ical	3 Suicide 6 Could not be	28e. Place of injury - At ho	me, farm, st			28f. Location (S	Street and Nur	nber or Ru	ıral Route Number,
$\leq$	lor / after Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify	1)			City or Ton	vn, State)		
	spita nours neral / fillet		29a. Certifier 1 Certifying Ph	ysician: To the best of my know	wledge, deat	h occurred at the ti	me, date and place	e, and due to the	cause(s) and i	manner as	stated.
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral dir	edical	(Check only 2 Medical Exar	niner: On the basis of examinat and manner stated.	tion and/or ir	vestigation, in my	opinion, death occu	urred at the time,	date and place	e, and due	to the cause(s)
	vithii To th	Me	29b. Signature and title of certifier	DI	11	29c. Licens	se number		29d. Date sigr	ned (Monti	h, Day, Year)
)			1 anna	81 Jantos	EVI	110	0641	7	01/22	/2008	3
			30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)		1			

Registrar

James P.
31. Date filed (Mon

Month Day, Year)
JAN 2 4 2008

DHMH 17 Rev 1/2001

arboe, M.D. 24035 Three Notch Road, Hollywood, MD 20636

Day, Year) Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 4:45 P. Blondine January 12, 2008 Boulware Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery HCR/Manor Care of Chevy Chase Chevy Chase If Under 1 Year | If Under 24 Hrs. 8. Date of Birth \_\_(Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 🛣 F 78 July 10, 578-36-6132 Yrs 1929 Virginia Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28e-1 show r than "natural", or iteme 23a or 28e-f sho 1X Yes 2 No District of Columbia Director Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2901 - 18th Street, N.W.; Apt. 216 20009 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after I ☐ Yes 2 **X** No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Georgetown University other than nentary/Secondary (0-12) College (1-4or 5+) 12th grade Operating Room Technician **Hospital** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If tem 27 is marked oth sny linjury or other treumatic event <u>ones.</u> Be (unknown) Ella Louise Boulware ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laverne Johnson (Daughter) 545 Brummel Court, N. W.; Washington, D.C. 20012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Jan. 15, 2008 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory, Inc. 21. Signature of Fineral Service 22. Name and Address of Facility R. N. Horton Co R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ovarian Cancer with Metastatic Disease years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physicien: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical the 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Failure to Thrive 1 Yes 2 No 3 Probably 4 NUnknown Dysphagia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA It Director: After this id in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

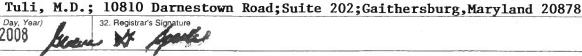
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and Itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 14, 2008

State Registrar

31. Date filed (Month, Day, Year)

JAN 1 5 2008

Raman R.



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Willis 9:00 R. Jefferson, Sr. $\mathbf{A}_{\mathsf{M}}$ 8, January 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5703 Longfellow Street Riverdale Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1**X**M 2□ F Min. 95 Yrs. 217-09-5883 9-20-1912 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ▼Yes 2 No Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5703 Longfellow Street 20737 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: **Black** 3√ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Enviromental Services GSA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert R. Jefferson Bertha Culley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys Jefferson (daughter) 5703 Longfellow St. Riverdale, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery 1/15/2007 Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Se vice Licensee 3401 Road 20722 Bladensburg Brentwood, MD 1 Sepul 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death teitlove Immediate Cause (Final disease or condition disease or condition resulting in death) Due to (or as a consequence of): mentension if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last onsequence of) Due to (or a Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical.

Physician

/Medical

**Examiner** 

MD

**Funeral** 

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

Director

Funeral

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Completed

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death with the Maryland

hours after

Baltimore, Maryland 21215-0036

Examiner Physician/Medical þ Completed Be Certification: To

burial-trar and attending physician for use as the huria detached be page 2 should certificate director, this After

The law requires that the death certificate be executed Physician; mpletely filled in by the funeral the Hospital or Attending 24 hours after death e Funeral Director:

Division or Vital Records, P.O. Box 68760,

within 2 ပ္ 3 State

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30. Name and address

in the past 12 months? 1□Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2☐ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, JAN 1 5 ZUUB

525 Greenway Center
32. Registrar's Signature

no completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 12:45 PM Shirley Maxine Kerns 01 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegan mberland Memorial Hospital Yyear If Under 24 Hrs. 2ays Hours Min. 8. Date of Birth (Month, Day, Year) Feb 2, 1926 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 □ F ΜD Director 213-24-5973 81 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Oldtown 1 □Yes 2□No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 22802 Oldtown Road SE 21555 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Maryland 21215-0036 Specify: Specify: ≥ 3 Widowed 4 □ Divorced white Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel McAtee Gross Leslie Herrell ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 Sandra Redinger daughter 417 Winmer St. Cumberland altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State **Davis Memorial Cemetery** 1/29/2008 Cumberland MD 4 Donation 5 Dother (Specify) 21. Signatur of Juneral Service Li 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part1 Ento the disease of common shock, or heart failure. List only immedia. Cause (Final riplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Approximate Interval Between Onset and Death atypertersive Arteriosclerotic Cardiovascular Diserces Physician 10 years disease or condition resulting in death) /Medical Examiner Diabetes Mellitus iO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Renal hronic attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, of Left Physician/Medical racture IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month 5 ☐ Other (specify) signed by the at d be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No or Attending Physician: after death. after death.

Director: After this certific in by the funeral director, 25. Was case referred to medical examiner?

↑ Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred Patient fell From bedsid Commade 28c. Injury at Work? 5 Pending investigation 1 Natural 01/20/2008 1 ☐ Yes 2 👿 No 8: 26 AM 2 Accident in hospital 6 ☐ Could not be 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Room 7414-2 WMHS-Memorial Campus To the Hospital or within 24 hours af To the Funeral D Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Registrar

924 Seton Drive Cumberland, MD
32. Registrar's Signature Poonai 31. Date filed (Month, Day, Year) JAN 3 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

A CONTRACT

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

22,2008

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 0525 AM 12008 balva anuary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner nestertown en7 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Min 1 □ M 2 X F Hours Yrs Director 217-86-3161 46 03/25/1961 MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 □XYes 2 □ No MD **KENT** CHESTERTOWN Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 335 LONGFELLOW DR. 21620 USA Funeral 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after i Hygiene. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. **7 is marked other than "r** College (1-4or 5+) Elementary/Secondary (0-12) 11 PAPER DELIVERY NEWSPAPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RICHARD KIMBLE VIRGINIA LECATES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. JEFF KIMBLE/BROTHER 14695 OAKLAND RD. RIDGELY, MD 21660 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESTER CEMETERY 1/17/2008 CHESTERTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 130 SPEER RD. CHESTERTOWN, MD 21620 23a Art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) STAGE END RENAL DISEASE **Physician** 48 /Medical Due to (or as a consequence of): **Examiner** years NEPHROPATHY DIABETIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the attending physician and detached for use as the burlal-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If ves. outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 ☐ Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No MURBID OBESIT 1 Tes 3 Probably 4 □Unknown Completed HYDVENTILATION SYNDROME 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an this certificate has autopsy performed? res 2 No 1☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 DOA P 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

1,55

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Regis

Noble

29c. License number

D004158

Sper Rd. Chestertown, MD

29d. Date signed (Month, Day, Year)

2008

Medical

29b. Signature and title of certifier

Helen 31. Date filed (Month, Day, ■ Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

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Funeral		5. Social Security N		7. Ag		a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	y, Year)	9. Birthp		Foreign
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or liems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	31955 RI	IVER RD				2165	1		U	SA		
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10	Physici /Medic		Robert James Kerr					Month January	Day 19 20	Year 108	8:20 a <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and num	nber)		4b. City, Town, or	Location of Death	- unually	4c. County		
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<b>1</b>	Funeral		5. Social Security Number 6. Sex 1 🕅 M 2 ☐ F	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		9. Birthpl Count	ace (State or Foreign try)
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b	filed wi Hygier other th	Be C	17. Father's Name (First, Middle, Last)		1111111	and neema	18. Mother's Name				
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Maryland 21215-0036	2 should be filed v n and Mental Hygie is marked other t raumatic event, th		19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (Street a	and Number or Run	al Route Number,	City or Town,	State, Zip	Code)
	1 and 2 Health em 27		Tanya Kerr/Wife		41460	Bea Cour	t, Leonar		4D 206	50	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from \$	State 20b. PI	lace of Dispo emetery, cren	sition (Name of natory or other place	e) [	Date 2	20c. Location -	City or To	wn, State
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Bai	permit. Departr Importa any inji		21. Signature of Funeral Service Licensee		22	. Name and Addres	s of Facility Bri	nsfield	Funera	1 Hon	ne, P.A.
			Edward N. Brinsfield,	Jr. MOC	052 2	2955 Holl:	ywood Roa	id, Leona	ardtown	, MD	20650
			23a. Part1. Enter the disease, or complications that can shock, or heart failure. List only one cause on each shock.	~ ~	. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	SI,		Approximate Interval Between Onset and Death
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	uted d ansit	Examiner	Sequentially list conditions, if any, badding to hime date cause. Enter Underlying Cause (Disease or injury that initiated events								
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Вох	The law requires that the death certifing the has been signed by the attending I age 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	come pf pregnai irth 2□Fetal	death 3	Ectopic pregnancy			23d. Dat	e of delive	ry Day Year
0	at the dea by the artached for	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	ant at time of de own	eath 5□	Other (specify)			19101	1141	Day Teal
<u> </u>	hat the deby		Part II. Other significant conditions contributing to de	ath but not resu	lting in the ur	nderlying cause give	n in Part I.	23e. Did tob	acco use contr	ribute to th	e cause of death?
Vital Records,	w requires that been signed b should be deta	d by	_ atteroscherate corar		•	, _ ,		1 <b>[</b> 2] Ye			ably 4 ∐Unknown
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Ř	The law cate has page 2 t	Completed						autops	y ngd? c	orior to con death?	npletion of cause of
ā			25. Was case referred to medical				26. Place of Deatl			I □ Yes	2 □ No
5	ysicla is cer direct	o Be	examiner?	npatient 2 🗆 E	ER/Outpatien	t 3 DOA Othe	۳۰.	me 5 AReside		er (Specify	<i>(</i> )
Division or	ig Ph ter thi	n: T	27. Manner of Death 28a. Date of Month	of Injury h, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho			/
Š	ath. or: Af he fur	atio	2 Accident investigation	n, Bay roar,	,=.,		res 2 □ No				
<u>S</u>	irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place buildir	of injury - At hor ng, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (Str City or Town	eet and Numb , State)	er or Rura	Route Number,
	urs af						1				
	e Hospital or Attending Physician: 24 hours after death. E Funeral Director: After this certifical letely filled in by the funeral director,	edical	29a. Certifier (Check only one) (Check only one)	asis of examinat	vledge, death ion and/or in	occurred at the time vestigation, in my op	ne, date and place, pinion, death occur	and due to the ca red at the time, da	iuse(s) and ma ate and place, a	inner as st and due to	ated. the cause(s)
	To the Hosl within 24 ho To the Fun completely f	Med	one) and mann 29b. Signature and title of certifier	ier stateu.		29c. License	number	29	d. Date signed	d (Month. I	Day, Year)
	D/		> M attend	رآمہ م		Doi	755 68		_	22	2 ***
•		1	30. Name and address of person who completed cause		23a) (Tvne.				1 (		
	4		Thomas M. Wilkinson, M.D.	23140	Moak]	ev Street	. Leonar	dtown M	ID 206	50	
100	Sta	te	31. Date filed (Month, Day, Year) 3 2008 32.	gistrar's Signat	ure	- 4	- J HEVIIGI				
×,	Registr	ar	JAN & 0 2000	Mary 1	O A						

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Edward Joseph Kozireski January 10, 2008 7:28P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Cheverly Prince George 8. Date of Birth (Month, Day, Year) Mar. 23, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 1934 New York **Funeral** 1 M 2 □ F 73 Months Days Hours Min. 121-24-7033 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov dical Examiner must be notified at 1 Yes 2 No Maryland | Prince George Capitol Heights Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1004 Quietview Dr. 20743 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite may injury or other traumatic event, the Medical Examines one. 1 Never Married 2 Married 2□No Korean Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: White 3 ☐ Widowed 4 🛣 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Construction Building Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Kozireski Grace ပ Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2145 Tamarac Trail Lusby, MD. 20657 Lisa M. Sarikaya/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kalas Crematory 4 □ Donation 5 □ Other (Specify) 1/12/2008 | Edgewater, Maryland 21. Signatur Funeral Service Licens 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a. Part1. Inter the disease, or complications that controls shock, or heart failure. List only one cause on the control of t aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, act line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician stritonitis disease or condition resulting in death) /Medical Due to (or as a consequence of): semmed divertibles Examiner perforated Sequentially list conditions Examiner if any leading to in medicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown piratory 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an certificate has be rector, page 2 s Hypertension 1∐ Yes 2 HNO director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician:

ours after death.

neral Director; A
filled in by the fu

Medical Certification: within 24 hours a

To the Funeral I

completely filled 15 State

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and manner stated 29b. Signature and title of certifier

6 ☐ Could not be

determined

29c. License number DU043662

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 1/10/08

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William ρς Ηυιρ 3001 Hospital Dr. Cheverly, Md. 20785 1304Ce

31. Date filed (Month, Day, Year)

JAN 1 5 ZUUG

2 Accident 3 ☐ Suicide

4 Homicide

29a. Certifier (Check only

32. Registrar's Signature It sports

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year JAN 26 GEORGE RICHARD LASHBAUGH, SR. 28 2008 07:05A /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 10625 NEW HOPE RD NW FROSTBURG ALLEGANY 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 ☑ M 2 ☐ F Director 216-14-1978 85 1922 MARYLAND SEPT 4 Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 □ No Director ALLEGANY MD FROSTBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be 21532 UNITED STATES 10625 NEW HOPE RD NW Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PIECE WORK BRICK MANUFACTURING permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANK J. LASHBAUGH MINNIE EISLER LASHBAUGH Pages 1 and 2 should inent of Health and Men ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10625 NEW HOPE RD NW FROSTBURG, MD 21532 MILDRED LASHBAUGH WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ROCKY GAP VETERANS 1-29-2008 FLINTSTONE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOWERS FUNERAL HOME, P.A. Sowers moosy7 60 W. MAIN ST., FROSTBURG, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** Heart Congestive 2 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼ No 24a. Was an page 2 s autopsy performed? res 2 No 1∐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Agesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural
2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours after death To the Funeral Director:

Medical

State

Registrar

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

WONSOCK SHIN

worsochelli

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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925 BISHOP WALSH RD

32 Registrar's Signature

29c. License number

00055325

Cumberland

29d. Date signed (Month, Day, Year)

21502

Jan 28, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month REV. JAMES SALVATORE LIPIANO 1:20P JAN. 21,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BRADFORD OAKS NURSING CENTER CLINTON PRINCE GEORGES If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Months LARGE, PA. Director 170-20-4096 95 MAR.8,1912 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND PRINCE GEORGES CLINTON 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6401 HELLEN LEE DRIVE 20735 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL CHAPLIN 12 <u>MINISTER</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH LIPIANO ၉ CLARA DIJOSIE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES LIPIANO, JR. WALDORF, MD. 20602 SON 3611 OLD WASH.RD. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State TRINITY MEM.GARDENS 1-26-08 WALDORF, MD. M00479 21. Signature of Funeral Service Licenses RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examine be executed as the burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown ZE NO Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 1∐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 NO Other: 1 ☐ Yes 4 Jursing Home မ 1 Inpatient 2 ER/Outpatient 3 DOA this 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred After Certification: Natural
2 Accident 5 ☐ Pending investigation 1 🗌 Yes death. 2 🗆 No To the Hospital or Attenct within 24 hours after death To the Funeral Director; completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Usertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

State Registrar

Date filed (Month, Day,

JAN 3 0 2008

DHMH 17 Rev 1/2001

of person who completed cause of death (Item 23a) (Type, Print

CIUNGUA

gistrar's Signa

			For State of Maryland /	Department of Health and MacCertificate of Death		7 H H R H 7 3 5
Ē	×	4	Decedent's Name (First, Middle, Last)	Cortinoato or Beatin	Reg. 2. Date of Death	No. 2 3. Time of Death
- 4	Physici /Medi		Ada Elizabeth Lenhart			Day Vear
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
2			Western Maryland Hospital C	tr Hagerstown		Washington
₩.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last to	Months Days Hours Min	8. Date of Birth (Month, Day, Ye.	9. Birthplace (State or Foreign Country)
0	Director		218-30-8421	Yrs. Substitution of the state	8/24/19	935 MD
	land bw It			wn or Location		10d. Inside City Limits
	Mary -f sh fied a	ţo	MD Washington Hage	rston		1 ☐ Yes 2 ☑ No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	th with	a D	14018 Poplar Grove Road	21742		USA
	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - American Indian,
98	or it		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☑ No Specify:	ilcan, etc.)	Black, White, etc.
8	172 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examiner must be notified at	d by	3 XWidowed 4 ☐ Divorced Year or Dates:			Specify: White
5	d within 72 ho giene. Ir than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)	<ul> <li>a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)</li> </ul>	g 16b.	Kind of Business/Industry
12	within iene. than " the Med	E	Elementary/Secondary (0-12) College (1-4or 5+)	Manager		
9	int,		17. Father's Name (First, Middle, Last)	18. Mother's Name		avel Agency
Maryland 21215-0036	0 ta 20 0	To Be	Arnold L. Rice		Faye Sta	
ary	2 should and Men is marke aumatic	_	19a. Informant's Name/Relationship (Type. Print) 19	b. Mailing Address (Street and Number or Rural		
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Baltimore,	of the property of		20a. Method of Disposition 20b. Place cemet 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	of Disposition (Name of Date of Page 1) Date of Date o	ate 20c.	Location - City or Town, State
<u>Ĕ</u>	Pages ment of I ant; If ite ury or o		4 □ Donation 5 □ Other (Specify) Mount	t Olivet Cem 1/26,	/2008 Fr	ederick, MD
alt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Setyrice Ucensee	22. Name and Address of Facility Kee		
_	205 20		John Whan M01176	106 East Church S	St Frede	rick MD 21701
п			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.			Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death)	ACQUIRED PNEUM	ONIA	Onset and Death
	/Medical Examiner			RENAL DISEASE		
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かって	execu n and al-tra	Exal	that initiated events resulting in death) Last C. Due to (or as a consequence	of):		· · · · · · · · · · · · · · · · · · ·
68760,	The law requires that the death certificate be executed its has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examine	d			
89	tifical ng phy as th	fedi				
Box	th cer endir r use	N/ue	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1□ Live birth 2 □ Fetal deat	h 3 Dectopic pregnancy		23d. Date of delivery
Э.	e dea he att ed fo	sici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death	5 Other (specify)		Month Day Year
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 23 Herbert Newton Lusby January 2008 1115 AM /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 319 Cherry Hill Road E1kton Ceci1 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye DEC 11, 1 Birthplace (State or Foreign Country) **Funeral** Months 1∑M 2□ F Director 79 220-20-5310 Marvland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Heatth and Mental Hygiene.
int: If Item 27 is marked other then "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "natural", or Items 23a or 28a-f shov traumatic event, the Modical Exemitines must be notified at Director 1 ☐ Yes 2 👿 No Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 319 Cherry Hill Road United States 21921 Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces? Korean
1 M Yes 2□No
1 Yes, Give
Year or Dates: War 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏋 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Quality Control Brick Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William A. Lusby ٩ Mary Jane Lair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Teresa M. Lusby/Wife 319 Cherry Hill Road, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery crematory or other place).

Immaculate Conception 2008 20a. Method of Disposition 20c. Location - City or Town, State ö 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Cherry Hill, MD 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the a lirector, page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 No Certification: To Be Completed 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2□No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cetting 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

10 71

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 W. High St.,

32. Registrar's Signature

M.D.,

Jamil Khatri

31. Date filed (Month, Day Year)

MD005408L

Suite 104, Elkton, MD 21921

January 23, 2008

Division or Vital Records, P.O. Box 68760,

s after dea. ral Director: Aff 0 To the Hospital within 24 hours a To the Funeral I

State Registrar 29a. Certifier (Check only

one)

31. Date filed (Month

29b. Signature and little of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KONICK, M.D. DANIEL J.

2008

115 SALLITT DRIVE, STEVENSVILLE, MARYLAND 21666 gistrar's Signature

1 🕅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D32353

29d. Date signed (Month, Day, Year)

JANUARY 14, 2008

			101		artment of Health an	d Mental Hyg	iene	
			1 - State Registrar	Cer	tificate of Death	R	eg. No. 2	02363
	Physici	an	Decedent's Name (First, Middle, Last)  ADDITION  TERROR			2. Date of Deat Month	th Day Year	3. Time of Death
-	/Medic		MARIE FRANCES	LOWE		JANUARY	13, 2008	2:30P M
	Examir	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of D	eath	4c. County of Deatl	
	a series years and decrease and a	*	FREDERICK MEMORIAL HOSPITAL		FREDERICK		FREDERICK	
	Funeral		1 □ M 2 1	vrs. last birthday) Yrs.	If Under 1 Year If Under 24  Months Days Hours	Min. (Month, Day,	, Year) Con	nplace (State or Foreign untry)
ů.	Director	(	217-34-0182 6  Usual Residence of Decedent	9		Dec. 23	, 1938 Mary	1and
	land ow	ļ		City, Town or Loc	cation			10d. Inside City Limits
	Mary -f sh lied a	ģ	Maryland Frederick Fr	ederick				1 ☐ Yes 2 XNo
	h the Marylan r 28a-f show notified at	Director	10e. Street and Number	edelick	10f. Zip Code	1	0g. Citizen of What Co	untry?
	h with		10525 Bethel Road		21702	110	SA	
	be filed within 72 hours after death with the Maryland that Hygiene.  Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in	n U.S. 13. V	Vas Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, P		14. Race - Amer	
9	after or Ite nine		Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ No If Yes, Give			uerto Rican, etc.)	Black, White	e, etc.
<u>ල</u>	ral",	l by	3 X Widowed 4 □ Divorced Year or Dates:	_   _ '	☐ Yes 2ሺ No Specify:		Specify: Whi	te
2	72 h 'natu dical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	ent's Usual Occupation kind of work done during most of	workina	16b. Kind of Business/I	ndustry
2	ithin ne. han '	ם	Elementary/Secondary (0-12) College (1-4or 5+)		OO NOT use retired)			
7	led w lygie her ti	ਠ	10	Super			Cleaning Fi	rm
Maryland 21215-0036	be ad c	Be	17. Father's Name (First, Middle, Last)		18. Mother's	Name (First, Middle, I	Maiden Surname)	
$\frac{8}{5}$	2 should be n and Menta ' is marked raumatic ev	P	Pete Sonifrank			L. Norris		
<u>a</u>	au is		19a. Informant's Name/Relationship (Type. Print)		g Address (Street and Number o		•	. –
	1 and Health Health Her tr		James L. Lowe, Jr.		Fairmount Road			
Baltimore,	e = 5		Tradular 2 Cremation 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		,	16/2008	20c. Location - City or 1	
	permit. Pag Department Important: any injury o	ļ.			g Methodist Cer		larksburg,	Maryland
g n	Depa Depa mpo any ii		2). Signature of uneral Service Licensee		Name and Address of Facility			
			yan M.		401 Ridge Road,			20872
			121. Enter the disease, or complications that cause the dishock, or lear failure. List only one cause on each ine.	1000		diac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Psus (Final disease or con tion a. resulting in death)		oumon1a			
	Examiner		Due to (or as a cons	sequence of):				
		-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cons	sequence of):				
	nted Insit	Examiner	cause. Enter Underlying	1				
,	execu n and al-tra	xal	that initiated events c.  resulting in death) Last  Due to (or as a cons	sequence of):		· · · · · · · · · · · · · · · · · · ·		
8/PU	icate be executed physician and s the burial-transit	dical l	d					
200	certificate be executed iding physician and ise as the burial-transit							
X Q Q	sician: The law requires that the death certific certificate has been signed by the attending i rector, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pre 23b. Was decedent pregnant				23d. Date of deli	very
מ	death e atten d for u	icia	in the past 12 months?  1 ☐ Ves 2 🗓 No  1 ☐ Ves 2 🗒 No		Ectopic pregnancy Other (specify)		Month	Day Year
S	t the	hys	9 ☐ Unknown 9 ☐ Unknown					
, O	requires that een signed b nould be deta	by P	Part II. Other significant conditions contributing to death but not	resulting in the un	derlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ğ	quire an sig uld b					1 □ Ye	es 2∐No 3∏Pro	obably 4 🕅 Unknown
ecords	aw re s bee	Completed				24a. Was ar		topsy findings available
r	The law ate has b	E				autops perform	ned? prior to c	ompletion of cause of
Z	an: rtifica tor, p	BeC	25. Was case referred to medical		26. Place of	1  Yes 2 Death (Check only one	21	2 □ No
	Physician: r this certific ral director,	To B	examiner?  1 Yes 2 No Hospital: 1 Timpatient 2	ER/Outpatient	Other:		ence 6 □Other (Spec	ify)
0	g Ph ter th		27. Manner of Death 28a. Date of Injury 1 ☐ Manual 5 ☐ Pending (Month, Day Year	28b. Time of Injury	28c. Injury at Work?		ow injury occurred	,
0	arth. or: Af	atio	2 Accident investigation	/ Injury	M 1 Yes 2 No			
DIVISION OF	er de recto by th	ti Liti	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - A building, etc. (Spe	t home, farm, stre	et, factory, office	28f. Location (St. City or Town	reet and Number or Ru	ral Route Number,
5	tal or	Certification:	3,			Only on Your	, otato)	
	lospi hour uner		29a. Certifier (Check only (Check only 2 Medical Examiner: On the basis of exam	knowledge, death	occurred at the time, date and p	lace, and due to the ca	ause(s) and manner as	stated.
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	ledical	and manner stated.					
	7 with 00 on 000 on 00 o	Σ	29b. Signature and title of certifier	1	29c. License number	756 25	9d. Date signed (Month	, Day, Year)
			La fait (/sml)	(11)	000329		January	13,2008
7	<b>)</b>		30. Name and address of person who completed cause of death (I					
_			Lamont C. Smith, MD, 400 West	Seventh	Street, Frede	cick, Mary	land 21701	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Repistrar's Signature 32. Repistrar's Signature 33. Repist	J. A	parti			
	nogisti	-		- //				

DHMH 17 Rev 1/2001

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			For State Registrar	State of Ma	aryland /	•	tment of I ificate of		Menta		000	0 00001	1
16	ye.		Registrar     Decedent's Name (First, Middle, in the content of the content	Last)		Cert	incate of	Death		te of Death	. No. /	3. Time of Death	4
	/sicia ledic		Kirk, Ladz	inski					Jan	vary	Day 11 20	08 1:41pm	
- Ex	amin	er	4a. Facility Name (If not institution, g	land Medica	1 Cente	er	46. City, Town,	or Location of Dea	ıth		4c. County of De	eath	
Fund Direct		4	5. Social Security Number 2/2-63		e (In yrs. last i	birthday)_ Yrs.	If Under 1 Year Months Days			te of Birth onth, Day, Y	1955 P	Birthplace (State or Foreign Country) CLRUIC NC	1
yland	at		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loca	ation					10d. Inside City Limits	-
he Mar 8a-fsh	otified	Director	DE Suss	ex	5700	Rya	TOWN			1.00	(148)	1 □ Yes 2 No	_
Deficiency (War) yield Z 12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show	nust be n	ral Dir	10e. Street and Number	Har S.	treet	_ '	10f. Zip Code	147			LISA		
after de or item:	niner n	Funeral	11. Marital Status 1 ☐ Never Married 2☐ Married	12. Was Decedent Armed Forces? 1			× 1	Hispanic Origin? ( ban, Mexican, Pue	specity y into Rican,	etc.)	Black, W	nerican Indian, hite, etc.	
hours a	al Exar	d by	3 ☐ Widowed 4 Divorced	Year or Dates:			☐ Yes 2 No			16	Specify:	Mita	
hin 72 an "nat	Medica	Completed	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)	grade completed)  College (1-4or 5		(Give k	ind of work done O NOT use retire	during most of wo	orking		I	ss/industry	
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uld be f Mental I	tic eve	To Be	Jack Melvin	· 1	/ski			Mary	16	bolar	a Cha	illou	
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paritit. Pages Department of I	ujury o		1 ☐ Burial 2 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)	Caf	Hal	CRINCH Name and Addr	vey 1/1	5/0	8 1	DOVER.	Dekiwari	1
Depa Depa	any II		21. Signature of Funeral Service Lic	- Shaw		Bo	nnia S	N ILL LA	1.71	7W.	DIVISIONS	Y DOVER DE	
10			23a. Part1. Enter the disease, or shock, or heart failure. List or	mplications that caused ly one cause on each li	the death. D	o not ente	the mode of dy	ing, such as cardia	ac or resp	iratory arres	t,	Approximate Interval Between Onset and Death	
Physic /Medi			Immediate Cause (Final disease or condition resulting in death)	W. Commission of the Commissio	MONIO a consequenc								
Exami	- 6	<u>.</u>	Sequentially list conditions,	b. Acute	e Res	_	tory I	Distress	5	yndr	ome		
executed in and	ansıt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.	a consequenc	Ju Oly.							
be exe	5 I	_	resulting in death) Last	Due to (or as	a consequenc	ce of):		,					
difficate	as the	Medic		d									_
res that the death certificate be executed igned by the attending physician and	ror use	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a	2 Fetal dea		Ectopic pregnand Other (specify)	СУ			23d. Date of o	delivery Day Year	
at the d	tached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown									_
w requires that been signed	De d	þ	Part II. Other significant condition	s contributing to death b	out not resulting	g in the und	lerlying cause gi	ven in Part I.	. 2	3e. Did toba 1 □ Yes		e to the cause of death?  Probably 4 Unknown	
) > Q'	page z sn	Completed	***************************************						.	4a. Was an autopsy performe □ Yes 2	24b. Were prior death	autopsy findings available to completion of cause of ? es 2 No	
/slcian	lirector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 npatie	ent 2∏ER/0	Outpatient	3□ DOA Ot	26. Place of De			ce 6 □Other (S	necifu)	
ing Phy offer this	Ineral		27. Manner of Death  1 ★Natural 5 Pending	28a. Date of Inju	ıry 28t	b. Time of Injury	28c. Inju	iry at ork?			injury occurred	респу	
Attendi death.	y me n	Certification:	2 Accident investigat 3 Suicide 6 Could not determine	be 28e. Place of inj	ury - At home,	farm, stree		Yes 2□No	28f. Lo	cation (Stre	et and Number or	Rural Route Number,	
urs after	lled in		4 [] Hornicide	building, et	tc. (Specify)				yr	ity or Town,			
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has	пріетеїу п	edical	(Check only one) 2 Medical Ex	Physician: To the best caminer: On the basis of and manner st	of examination	dge, death and/or inve	estigation, in my	opinion, death oc	ce, and du	the time, dat	e and place, and	due to the cause(s)	
To To	000	2	29b. Signature and title of certifier  **Rembedie Terrifier**	Taylor-cla	Hie, M	l.D.	RES	Se number			i. Date signed (Mo	11,2008	
			30. Name and address of person which is the state of the	o completed cause of d	leath (Item 23a	a) (Type, P	rint) D, 26	2 South	Green	ne St.	Baltimore	, MD 21201	
Re	Sta gistra		31. Date filed (Month, Day, Year)  JAN 1		rar's Signature	40 0	A			-			
DUMU 17 B			ALII T			7							_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Frances Gertrude Moore DANUARY /Medical 22,2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Home 10 **Funeral** 1 □ M 2X F West Virginia 85 Director 233-34-3908 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director MD Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 322 North Earlton Road 21078 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: r than "natural", or the Medical Examir Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White 35Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within ealth and Mental Hygiene. n 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 10 Press Operator Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Hart Ada Mayfield ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is Ellen Mayfield (Daughter-in-law) 322 North Earlton Rd Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Inluny 4 □ Donation 5 □ Other (Specify) Bel Air Mem. Gdns. 1/25/08 Bel Air, Maryland 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 21. Signature of Funeral Services Licensee any Tarring-Cargo Funeral Home. Aberdeen, Maryland 21001-3

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** wonary artury disease or condition resulting in death) /Medical Due to (or as | come puence of): timation Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Cerebrovaswan burial-transit and Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 2 □ No 3 Probably 4 Donknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has page 2 this certificate 2 No 1□ Yes Division or Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation within 24 hours after dean...

To the Funeral Director: Af 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32/Pegistrar's Signatur

Mion

29c. License number

29d. Date signed (Month, Day, Year) 23

**Funeral** Director

Baltimore, Maryland 21215-0036	permit, Pages 1 and 2 shou	Department of Health and Mental Hygiene.	
DIVISION OF VITAL RECORDS, P.O. BOX 68/60,		witnin 24 nours arter gearn. To the Funeral Director: After this certificate has been signed by the attending physician and	этрете in by the funeral director, page 2 should be detached for use as the burial-transit

		For State Registrar	Otato of Ma	i ylaria i	-	tificate of I	Death		g. No. 2008	02366	
Physicia	an	1. Decedent's Name (First, Middle			74 J .	100		2. Date of Death Month	2 <sup>Day</sup> , 2008 <sup>ar</sup>	3. Time of Death	
/Medic		Laurence	William		Mil			January		2:00 р м	
Examin	er	4a. Facility Name (If not institution,					Location of Death		4c. County of Death		
		7021 S. Flin  5. Social Security Number		/lm run la at	la luith ata)	If Under 1 Year	ings If Under 24 Hrs.	8. Date of Birth	Calver		
uneral irector		246-44-2213 Usual Residence of Decedent	tX M 2 ☐ F	(In yrs. last	Yrs.	Months Days	Hours Min.	(Month, Day,	Year) Cou	place (State or Foreign intry) th Carolina	
t pw		10a. State 10b. County		10c. City, T	own or Lo	cation				10d. Inside City Limits	
f sh	tor	MD Calve:	rt			Owi	ings			1 □Yes 2 XNo	
r 28a notii	Director	10e. Street and Number				10f. Zip Code	11190	10	g. Citizen of What Cou	untry?	
3a ol st be		7021 S. Flin	F Hill Boad			201	736		USA		
ms 2	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. V		ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Amer		
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2X Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ⊠ Yes 2 □ N If Yes, Give Year or Dates: 1	。 957–5		Yes 2∏ No	Specify:	nican, etc.)	Specify: wh	ite	
'natur dical	eted	15. Decedent (Specify only highes	s Education t grade completed)	1	6a. Deced	ent's Usual Occup	ation during most of work f)	ing	6b. Kind of Business/li	ndustry	
than the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5-						Federal Go	vernment	
other vent, t	Be Co	17. Father's Name (First, Middle, I			Juage	c anarys		e (First, Middle, M		VCEIIICIIC	
rked fic e	To E	Laurence Wi	lliam Mill	er			Vivian	Rebecc	a Newton		
s ma	11	19a. Informant's Name/Relationsh	ip (Type. Print)	1	19b. Mailin	g Address (Street	and Number or Rui	al Route Number,	City or Town, State, Z	ip Code)	
n 27 i		Trinna L. Mille	er, spouse						s, MD 2073		
if iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐Removal from State	20b. Place ceme	e of Dispos etery, cren	sition (Name of natory or other plac		Date 2	20c. Location - City or T	Town, State	
tant: jury		4 □ Donation 5 □ Other (Sp	ecify)	Metr			atory 1-		Alexandria,		
Impor any ir		21. Signature of Funeral Service I	R. Glo	~		Name and Address	I\a		eral Home, ngs, MD 20		
		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each line	the death. [	Oo not ente	er the mode of dyin	ig, such as cardiac	or respiratory arre	st,	Approximate Interval Between	
sician		Immediate Cause (Final disease or condition resulting in death)	_a. Eso,	shag	eal	can	cer			Months	
ledical aminer		roodiling in doutry	Due to (or as	consequen	ce of):						
	er	Sequentially list conditions, if any, leading to immediate	b	consequen	ce of):						
ld ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
ng physician and as the burial-transit		resulting in death) Last	Due to (or as a	consequen	ce of):						
phys s the	Medical		d								
To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 3 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal de	ath 3□	Ectopic pregnancy Other (specify)	'		23d. Date of deliv Month	very Day Year	
ed by		Part II. Other significant condition	ns contributing to death bu	t not resultin	g in the un	derlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?	
en sigr	ed by							1 □ Ye	s 2⊠No 3∏Pro	obably 4 □Unknown	
e has bee	Completed							24a. Was an autopsy perform	prior to coned? death?	topsy findings available ompletion of cause of	
tificat or, pa		25. Was case referred to medical					26 Place of Deat	1  Yes 2 h (Check only one	Man 1 ☐ Yes	2 No	
is cer direct	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatier	nt 2□ER/	Outpatien	3 DOA Oth			nce 6 □Other (Spec	ify)	
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I Directo	Certification	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ry - At home . (Specify)	, farm, stre	eet, factory, office		28f. Location (Str City or Town	eet and Number or Ru , State)	ral Route Number,	
e Funera	edical C	29a. Certifier 1 Certifying 2 Medical I	g Physician: To the best of examiner: On the basis of and manner stat	examination	dge, death and/or inv	occurred at the tir restigation, in my o	ne, date and place, pinion, death occur	and due to the carred at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)	
To th co⊞p.	Me	29b. Signature and title of certifier	0.0			29c. License			d. Date signed (Month		
\		) stable	met			POOS	9061	7	anuary 2	7th 2008	
541		30. Name and address of person of Partel	110 HUSP	17tal	a) (Type, I	d Svi	H 212	- Prin	anuary 20	20648 MD	
Sta Registr		31. Date filed (Month) Day. Ban	2008 32 Registra	rs Signatu	1	ed)					

			For State	State of Ma	aryland / Depa	artment of H		,	2000	00007
L.	Mes-		Registrar  1. Decedent's Name (First, Middle	e. Last)	CE	rillicate or i	Jeani ———	2. Date of Dea	Reg. No	3. Time of Death
	Physici /Medi			hirter				Month	y24,2008	8:45 A M
	Examir		4a. Facility Name (If not institution			4b. City, Town, or	Location of Deat		4c. County of Deat	
The same	to the second second	4	2900 Ridge			Windso	or Mill		Baltim	ore
4	Funeral Director		5. Social Security Number	6. Sex 7. Age 1	e (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	y, Year)   Co	thplace (State or Foreign buntry)
-4	simonethe, elle eele	1	237-26-0774 Usual Residence of Decedent		04			March2	8,1923 Noi	rthCarolina
	within 72 hours after death with the Maryland lene. Itan "natural", or Items 23a or 28a-f show he Medicat Examiner must be notified at	_	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	he Ma 18a-f s	Director		timore	Windsor					1 ☐ Yes 2X No
	a or 2		10e. Street and Number	_		10f. Zip Code			10g. Citizen of What Co	ountry?
	ns 23 must	Funeral	2900 Ridge R	12. Was Decedent B	Ever in U.S. 13.	21244 Was Decedent of Hi	ispanic Origin? (5	Specify Yes or No-	U.S.A 14. Race - Ame	rican Indian.
9	after o	Fun	1 ☐ Never Married 2 Marr	Armed Forces?	Vo	Was Decedent of Hi If Yes, specify Cuba		to Rican, etc.)	Black, White	e, etc.
8	iours a	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify: Wh	ite
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פַ	a filed tl Hyg other ent, i	Be C	17. Father's Name (First, Middle,	Last)		1	18. Mother's Nar		Maiden Surname)	
<u>/lar</u>	uld be Menta arked aric ev	To B	Murdick Fen	nel Johnso	n		Lucy A	nn Robe	rte	
lan,	2 sho rand l is me	1	19a. Informant's Name/Relationsl		- 1	ng Address (Street a	and Number or Ri	ural Route Numbe	er, City or Town, State, 2	Zip Code)
ر به	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  any injury or other traumatic event, the Medical Examiner must be notified at once.		Robert McWhi: 20a. Method of Disposition	rter/Husba	nd 2900	Ridge R	oad, Win	ndsor M	ills,Mary	land21244 Town, State
altimore,	ages int of h		1 ☐ Burial 2 ☐ Cremation							
<u> </u>	artme artme ortani injun		4 ☐ Donation 5 ☐ Other (S <sub>i</sub> 21. Signature of Funeral Service		Bayview	Cremato  2. Name and Addres	ry 1-2	25-08	Baltimore	, Maryland
m	any per		mushed 1	merullo	6.0	.ΛQ Uarf	ord Do	arzullo	Funeral	Chapel, P.A.
	0 23.0	į	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lir	the death. Do not ent	er the mode of dying	g, such as cardia	c or respiratory ar	rest,	vland21214 Approximate Interval Between
₹, F	Physician	ì	Immediate Cause (Final disease or condition	Col	oblasten		Myorr			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):	7-66	7			
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Box	I ne law requires that the death certific ite has been signed by the attending p vage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Date of del	,
P.O.	at the dea by the ar	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify)			Month	Day Year
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Vital Records,	turres n sign lid be	d by	4 .	cus						obably 4 □Unknown
S	aw requires been six	Completed						24a. Was a	an 24h Were au	itopsy findings available
2	cate has l page 2 s	omp						autop: perfor	sy prior to death?	completion of cause of
		BeC	25. Was case referred to medical examiner?				26. Place of Dea	1  Yes ath (Check only or		2□No
	Auending Physician: r death. ector: After this certific. by the funeral director, I	10	1 Yes 2 No		nt 2 ☐ ER/Outpatien		4 Li ivursing n	lome 5 Resid	ence 6 Other (Spec	cify)
Division or	After 1		27. Manner of Death 1. ■ Natural 5 □ Pending	28a. Date of Injur (Month, Day		Work		28d. Describe h	ow injury occurred	
ISIC	death ctor: ,	Certification:	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ot be   290 Place of inju	ry - At home, farm, str		Yes 2 □ No	29f Loostian (C	tract and Municipal or Co	umi Conta Minata
2	P = = =	ertif	4 ☐ Homicide determi	building, etc	(Specify)	set, factory, office		City or Tow	treet and Number or Ru n, State)	irai Houte Number,
1	e nospital or 124 hours afte e Funeral Dir letely filled in		29a. Certifier 1 Certifyin	g Physician: To the best o	of my knowledge, death	occurred at the tim	ne, date and place	i e, and due to the o	cause(s) and manner as	stated.
1	o the hos within 24 ho To the Fun completely	edical	(Check only 2 Medical I one)	Examiner: On the basis of and manner sta	examination and/or in ted.	vestigation, in my op	oinion, death occu	urred at the time, o	date and place, and due	to the cause(s)
,	vithin 2 To the	Σ	29b. Signature and title of certifier	- 120		29c. License	number	2	29d. Date signed (Month	h, Day, Year)
,				MAN		U	00047	0	1125108	3
	6		30. Name and address of person v	who completed cause of de	eath (Item 23a) (Type, 2700	Print)	1 Inho	Bino	pollow	to the cause(s)  th, Day, Year)  Boolery 2/2/9
	Sta	te	31. Date filed (Month, Day, Year)		r's Signature	Que V	t cont	a not	1/4/10/100	,
	Registr		JAN 3 C	2008	r's Signature	aside.				

			For State	State of Ma	aryland / De		of Health a			•	2000	023	260
			Registrar  1. Decedent's Name (First, Middle, Li	net)		erinicale	or Death		2. Date of De	Reg. No	2000	3. Time of	Death
	Physicia			•					Month	Day			$\mathbf{P}^{M}$
	/Medic Examin		Carol Jean Muscar 4a. Facility Name (If not institution, gi			4b. City, To	own, or Location		January		County of Death	8:20	<u>P</u>
	LXBIIIII		Shady Grove Adver	tist Hospi	tal	Rockv	ille			Мо	ntgomery		
N.,	Funeral	2	5. Social Security Number 6.		e (In yrs. last birthda	y) If Under 1 Months D	Year If Under Days Hours	Min.	8. Date of Birl (Month, Da	y, Year)	Cou		r Foreign
	Director	ģ.	282-34-5056 Usual Residence of Decedent		69 Yrs.			_   A	August	19,	1938 Oh	io	
	laryland show ed at		10a. State 10b. County		10c. City, Town or	Location						10d. Inside Cit	·
	a-fsh iffied	ctor	Maryland Montgome	ry	Gaithers	burg						1 ☐ Yes	2 X No
	ith the	Directo	10e. Street and Number		_	10f. Zip Co	ode			10g. Cit	izen of What Cou	ntry?	
	ath w	ral	21801 Glendalough		5 1 110 14	2088			, , , , , , , , , , , , , , , , , , ,	USA	14. Race - Ameri	Indian	
	items items iner n	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 📉	Everin U.S. 1;	If Yes, specify	nt of Hispanic Ori y Cuban, Mexical	n, Puerto F	Rican, etc.)	-	Black, White,		
200	urs af al", or xami	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🕅	No Specify:				Specify: Wh	ite	
	be filed within 72 hours after death with the Maryland tal Hygiene.  d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest g		16a. Dec	cedent's Usual (	Occupation done during mos	st of workin	a	16b. K	ind of Business/Ir		
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Š	2 should and Mer Is marke raumatic	၉	19a. Informant's Name/Relationship		19b. Ma	iling Address (S			len Day		or Town, State, Zi	p Code)	
2	o ≠ 7: ≠ o		Joseph Muscara, h	usband	218	01 Gleno	dalough	Road	. Gaitl	nersi	burg, MD	2088	2
ָר ב	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3		20b. Place of Dis				ate		ocation - City or T		
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ָם ב	permit, Pages Department of I Important: If ite any Injury or ot once.		21. Cignature o Funeral Service Lice	nsee							lliams F		Home
	20 = 8 O		230 Ball Estathadianan er sa	Due			idge Roa				aryland	20872 Approximate	Α.
		9 1	23a. Pa 11. Enter the disease, or color shipting the the disease, or color shipting the color shipting the sales (Final Immediate Sales (	one cause of each li	ne.	anter the mode to	or dying, such as	cardiac oi	теѕрпатогу а	iresi,		Interval Bet Onset and I	ween
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6	10/04	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as	a consequence of):								
	cuted nd ransit	Examiner	that initiated events	C									
5	e exe ian ar urial-t		resulting in death) Last	Due to (or as	a consequence of):								
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	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant a	2 Fetal death	B⊟Ectopic preg					Month	,	Year
;	the d by the ached	Physician/Me	1 ☐ Yes 2 🔼 No 9 ☐ Unknown	9□Unknown			,,						
ָרְ ר	s that ned b e deta	by PI	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cau	ise given in Part I	l.	23e. Did t	obacco	use contribute to	the cause of c	death?
<u>.</u>	equire en sig ould b	ed k			· · · · · · · · · · · · · · · · · · ·				1 🗆	Yes	No 3□ Pro	bably 4 □l	Unknown
ָ נ	as be 2 sho	Completed							24a. Was		24b. Were aut	opsy findings empletion of c	available ause of
ב =	The ate h	Som							perfo	ormed? 2 💢 No	death?	•	
N 110	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				e of Death	(Check only o	one)			
5 1	Physical direction	7 2	1 Yes 2 No  27. Manner of Death	28a. Date of Inju					ne 5 Resi 8d. Describe		6 □Other (Spec	ify)	
5 :	ding h. After funer	tion	Natural 5 ☐ Pending investigation	(Month, Da		M Z	c. Injury at Work? 1 ☐ Yes 2 ☐		od. Describe	now inju	ry occurred		
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5	s after al Dir	Certification:	4 Hollicide	building, et	c. (Specify)				City or To	wn, State	e)		
:	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 44 hours after death.  To the 24 hours after death.  To the Puneral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (		hysician: To the best miner: On the basis o and manner st	f examination and/or								s)
:	within To the compl	Me	29b. Signature and title of certifier	. / -		29c. L	License number			29d. Da	ite signed (Month	, Day, Year)	4,
			) Ugn	UE in	1117	5	3177	_		1/1	4/08	201	28
Y			30. Name and address of person who	completed cause of d	leath (Item 23a) (Typ	e, Print) 7 WGC	GCAL (	Ceri	- M 1.	W.	Prect	16/61	878

State Registrar

31. Date filed (Month, Day, Year)

JAN 1 7 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:20PM 2008 MACINDOE JANUARY WILLIAM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner TALBOT TRAPPE 2150 OCEAN GATEWAY 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day. **Funeral** 1[**X**M 2□F Months Days Hours NEW YORK JULY 22, 1937 70 218-34-9475 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d, Inside City Limits 10b. County 28a-f show ral", or items 23a or 28a-f sh Examiner must be notified 1 ☐ Yes 2 No Director TALBOT TRAPPE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21673 USA 2150 OCEAN GATEWAY r death ∖ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: I flem 27 is marked other than "natural", or fte ury or other traumatic event, the Medical Examine ury or other traumatic event, the Medical Examine 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LAW ENFORCEMENT OFFICER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSEPHINE HOPKINSON ROBERT MACINDOE ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important; If Item 27 is any injury or other trau once. BEVERLY H. MACINDOE/WIFE PO BOX 24, TRAPPE, MARYLAND 21673 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 1/10/2008 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 MERCERON JOHN F 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carcinona Physician UUS 4-ears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner eas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify)

or Attending Physician: The law requires that the death certificate be executed O. Box 68760 Division or Vital Records, P. Director: within 24 hours aft To the Funeral Di completely filled in

ဥ

Certification:

Medical

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

Baltimore, Maryland 21215-0036

6+IVA

State

Registrar

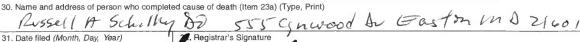
80 Russell A Schiller 31. Date filed (Month, Day, Year)

JAN 1 1 2008

world a . Scheley

5 Pending investigation

6 ☐ Could not be



28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

01-10-2008

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Jennings Ode McCune Jan 9 2008 8:00 PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Genesis HealthCare -The Pines Easton Talbot 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, AUG 9, 9. Birthplace (State or Foreign **Funeral** Days 1**X** M 2□ F Hours Min. 1914 WEST VIRGINIA Director 236-16-9219 93 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1X Yes 2 No **GASSAWAY** Director BRAXTON WVA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 26624-1403 209 HIGHLAND ST. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iten 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: WHITE 3 X Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STATE GOVERNMENT FOREST RANGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DORA V. BOWLING ۵ ALFRED G. McCUNE or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29790 APPLE DRIVE, CORDOVA, MD 21625 CAROLYN HAILEY/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. CHESAPEAKE CREMATION CTR 1/10/2008 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 Estroute Joseph m. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trai Due to (or Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, f 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1-10-08 30. Name and address of person who completed cause of death (Item 26a) (Type, Print) 7+VA 610 (ROWLEY CHMANS 31. Date filed (Month, Day, Year) State 2008 Registrar

			1 - For State Registrar	State of Maryland		irtment of I			giene Reg. No.2	08	02	371
I	Physici		1. Decedent's Name (First, Middle, Las Valerie D. McC					2. Date of De Month	Day	Year 2008	3. Time o	f Death  A M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of D	January Death	4c. County		1.1	n
	LAGIIII		3542 Blackberry	Lane		E11:	icott C	ity	Hov	ward		
	Funeral		Social Security Number     6. Security Number	TH NOTE		If Under 1 Year Months Days		Min. (Month, Da	v. Year)	9. Birthpla Countr	γ)	or Foreign
É	Director		518 48 1360 Usual Residence of Decedent	64	Yrs.			Oct. 8	1943	Illin	ois	
	land ow		10a. State 10b. County	10c. City	, Town or Lo	cation				100	d. Inside C	City Limits
	Mary Firsh	to	MD Howard	i El	licott	City					1 🗌 Yes	2 <b>X</b> No
	in the	irec	10e. Street and Number	1		10f. Zip Code			10g. Citizen of	What Countr	y?	
	23a c	Funeral Director	3542 Blackberry La	ine		2104:	2		USA			
	tems	unei	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Vas Decedent of Yes, specify Cub	Hispanic Origin oan, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	- 14. Ra	ce - America ck, White, et		
36	rs afte	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 XNo If Yes, Give Year or Dates:		☐Yes 2XNo	Specify:		Specif	y: White	е	
5-0036	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be multified at	ted	15. Decedent's Ed	ducation	16a. Deced	lent's Usual Occu	pation		16b. Kind of B	Business/Indu	ustry	
215	hin 7.	pie	(Specify only highest gra- Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give lite. L	kind of work done OO NOT use retire	during most of ed)	working				
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Maryland 2121	2 should be filed within and Mental Hygiene. Is marked other than aumatic evant, the Mental aumatic evant.	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,	Maiden Sumai	пө)		
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Mai	nd 2 shallth and 27 ls n		19a. Informant's Name/Relationship (7			353		or Rural Route Number			3	
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Charles Garrison 20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of	_	ne Ellico Date	20c. Location	- City or Tow	2 <u>104</u> m, State	.2
altimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe once.		1 Burial 2 Cremation 3 :	Hemovai from State	-	natory or other pla cematory		16/2008	Hanover	. MD		
	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Lices	7755 7 76				Harry H. V			Ly FE	Inc.
ä	Depa Impo any i		Plenon L.K	cade	41	12 Old (	Columbia	a Pk. Ell	icott (	City, M	MD 21	.043
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death one cause on each line.	. Do not ente	er the mode of dy	ing, such as car	rdiac or respiratory a	rrest,	1	Approxima Interval Be	tween
	Physician		Immediate Cause (Final disease or condition	. LUNG-	CAY	UCER				~	Onset and	Death DVTTH
- 20	/Medical Examiner		resulting in death)	Due to (or as a consequ								-
b,	LAGITITICI	<u>.</u>	Sequentially list conditions,	b. Due to (or as a consequ	ores off							
	ted nsit	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 101 83 8 00113340	ence cry.							
<u>,</u>	execunand and ial-tra	Exar	that initiated events resulting in death) Last	c. Due to (or as a consequ	ience of):							
760,	death certificate be executed e attending physician and of for use as the burial-transit	lcai		d								
9	ntifica ng ph as th		IF FEMALE:					554.50				
Вох	eath certifii attending ; I for use as	Physician/Med	23b. Was decedent pregnant in the past 12 menths?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3 [	Ectopic pregnanc	у			ate of delivery	•	Year
0.	the at	/sici	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of de 9□ Unknown	eath 5□	Other (specify) _				51101	, u y	100.
۵.	The law requires that the de ite has been signed by the a bage 2 should be detached f	Ph	Part II. Other significant conditions co	ontributing to death but not resu	Ilting in the ur	nderlying cause gr	ven in Part I.	23e. Did t	obacco use con	tribute to the	cause of	death?
Records,	uires sign ld be	d by		-	-			ix	yes 2 □ No	3 Proba	bly 4	Unknown
CO	w require been signature should b	iete						24a. Was	an 24b.	Were autops	sy findings	available
Re	The lay te has age 2	Completed							rmed?	prior to complete.  1 Yes 2	pletion of	cause of
Vital		a)	25. Was case referred to medical				26. Place of	1 ☐ Yes  Death (Check only of	7	103 2		
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Division of	ng Ph After th Joeral		27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo		28d. Describe	now injury occu	rred		
Sio	r Attending P er death. rector: Atter t by the funera	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 No	006 1	DA		0	-tra-
$\leq$	or Al after of Direction by	artif	4 ☐ Homicide determined	28e. Place of Injury - At hose building, etc. (Specify,	me, rarm, str	eet, ractory, office		City or To	Street and Num vn, State)	ver or Hurai	HOUIÐ IYUI	noer,
_	To the Hospital or Attens within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best of my know	wledge, death	occurred at the t	ime, date and o	place, and due to the	cause(s) and m	anner as sta	ted.	
	To the Hospita within 24 hours To the Funeral completely filled	edicai	(Check only 2 Medical Examone)	niner: On the basis of examinati and manner stated.	ion and/or in	estigation, in my	opinion, death	occurred at the time,	date and place,	, and due to t	the cause(	s)
	To th withir To th comp	Me	29b. Signature and title of certifier	)			se number		29d. Date signe	ed (Month, D	lay, Year)	
			) setella			145	014		JANUM	cy 15	120	08
0	42		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)		VREL M	1 2 - 7	27		
	W -			RTIRE NO 83	343 C	tivity	N- N	VKCZ /	00/	<i>J</i> (		
400	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signat	D. D.	certi						

08-00353 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Kelvin McClearn 02372 2008 1- For State Certificate of Death Reg. No. Registrar 3 Time of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ ¥ear 2100 hrs **Medical Examiner** McClearn January 12, 2008 Kelvin 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Penninsula Regional Medical Center Salisbury Wicomico If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign Washington 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Min. Months Davs Hours Jan. 27, 1957 Director 217-64-8118 50 Country) D.C. 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits Oc. City, Town or Location 1 X Yes 2 No Upper Marlboro Prince Georges items 23a or 28a-f show Maryland Director 10f. Zip Code 10g. Citizen of What Country 10e Street and Number 12001 Kingfield Ct. 20772 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status Was Decedent Ever in U.S. Armed Forces? White, etc. 1 Never Married 2 Yes Yes. Give Year Widowed 4 X Divorced Yes 2 X No specify. Specify: Black ≥ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) t. Pages I and 2 should be filed within 72 h truent of Health and Mental Hygiene. reant: If item 27 is marked other than "n. or other traumatic event, the Medical Fa Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Brick Finisher/ Concrete Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) McClearn Thomas Christene Penny 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Christene McClearn-Mother Kingfield Court, Upper Marlboro, MD. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State 1/21/2008 portant: Suitland, Maryland <u>Washington National</u> Donation 5 Other Specify ō Signature of Funeral Service Licenses Forestville, MD. 20747 Pope Funeral Homes PA 5538 Marlboro Pike Approximate Interval 23a, Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical X UNPENDED #MENDED, perME, g876, 2/14/08 TT attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 5 Yes 2 No 3 Probably 4 V Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Other<sub>4</sub> examiner? Hospital Inpatient 2 V ER/Outpatient Nursing Home 5 Residence 6 3 this 1 Yes ۵ 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No Pending. Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mip January 13, 2008 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 3 JAN 1 6 2008 32. Registrar's Signature State Registra

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** January 8, 2008 11:26 A Aaron McGue, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton 5702-F Spring Street If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 X M 2 □ F Director June 30. 1938 West Virginia 69 233-52-7045 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show "natural", or items 23a or 28a-f shovidical Examiner must be notified at 1 ☐ Yes 2 ☐ No California Director St. Mary's Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20619 United States 45270 Woodstown Way Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian. Black, White etc. African 11 Marital Status within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 2 3 Widowed 4 Divorced American Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Construction Worker 3 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosanna Curry John Wesley McGue, Sr. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health Important: If item 27 i any Injury or other tra once. Health tem 27 6215 Trotters Glen Dr. Hughesville, MD 20637 Sharnette A. White - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery Jan 15, 2008 Clinton, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service 4001 Benning Road, NE Washington, DC 20019 23a. Partl. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Hanging /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has autopsy performed? 1□ Yes XX No Decedent's funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence &XOther (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∭Yes 2☐ No ၉ this 28d. Describe how injury occurred Subject 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: After 1 □ Natural 5 Pending 11:15 P<sup>M</sup> 1 XYes 2 □ No investigation Jan 7, 2008 hung himself in warehouse 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760, P.O. | Division or Vital Records, or Attending Physician:

s after dea... ral Director: Aft

within 24 hours a
To the Funeral |
completely filled To the

Medical 12

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvador Sylvester 31. Date filed (Month, Day, Year) State

JAN 15

2008

29b. Signature and title of certifier

4 ☐ Homicide

(Check only

29a. Certifier

and manner stated.

Warehouse

29c. License number 29d. Date signed (Month, Day, Year)

5702-F Spring St Clinton, MD

11, 2008

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

3001 Hospital Drive Cheverly, MD 82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amended #4a per Phy, 96/15/08 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MIRZA 0135 **Physician** 7 ENAB 2008 to /Medical 4b. City, Town, or Location of Death Laurel Annapolis 4c. County of Death Prince Georges 4a. Facility Name (If not institution, give street and number) Examiner Hospice of Anne Chesapeake Arunde I If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days 0170171923 1 M 2 Months 215-63-6828 85 Pakistan Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ☐ Yes 2 No ral", or Items 23a or 28a-f sh Examiner must be notified Director MD Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20724 3381 Horsehead South Pakistan Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2**½** If Yes, Give Year or Dates: 2**/2**] No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€ No Asian Specify: þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical than Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home s 1 and 2 should be filed if Health and Mental Hygin Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hajji Fazal Dad Hassan Bi ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3615 Cherryvale Dr., Beltsville MD 20705 Riaz Mirza / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot Burial 2 □Cremation 3 □Removal from State Maryland Natl.Ceme 01/03/08 Laurel, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Washington, DC 20011 Universal Mortuary, 411 Kennedy St.NW 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Weeki **Physician** resulting in death) /Medical Due to (or as a consequence of) len Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sells conesquence offr Examiner and Due to (or as a consequence of) as the burial-P.O. Box 68760, signed by the attending physician I be detached for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 | Fetal death in the past 12 months?

1 Yes 2 2 No
9 Unknown Month Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 9 1 | Yes 2 | No 3 | Probably 4 | Dunknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an cate has t page 2 s certificate 1∏ Yes 2 or Attending Physician; 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Other (Spe 25 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 2 this Kenden To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 1 Watural 5 □ Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) Ē. completed cause of death (Item 23a) (Type, Print)

A W 441 DIFFOSE H6HWAY A EN 32. Renistrar's 31. Date filed (Month 2008 Year) State Registrar

DHMH 17 Rev 1/2001

08-00344 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Wallace Evans McLaughlin 1- For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Deat Physician/ Month Day January 12, 2008 Wallace Evans McLaughlin 0930 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Center Cheverly Prince George's 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Country) Va. Foreign Months Davs Hours 227-54-2139 Director 09/28/1940 67 1x M 2 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Capitol Heights Md. Prince Georges 1 X Yes 2 No 28a-f show notified at once, with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20743 U. S. A. 5923 Central Avenue 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Mantal Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. death v Never Married 2 Yes Black. 10 4 X Divorced If Yes. Give Yea Yes 2 X No specify. Specify. hours after Widowed 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 72 of Health and Mental Hygiene.
If item 27 is marked other than "ther traumatic event, the Medical Gov't Printing Office Press Operator Baltimore, MD 21215-0036 and 2 should be filed within 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lena Bell Martin Robert Evans McLaughlin Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20784 2 19a. Informant's Name/Relationship (Type, Print.) Vincent McLaughlin (Son) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) other 1 Pages 1 1 X Burial 2 Cremation 3 Removal from State permit. Pages
Department of
Important: Family Cemetery 01/19/2008 Goochland, Va. Donation 5 Other Specify: 5 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 0 W.H. Bacon Funeral Home, Inc. 3447 14th Street, N.W. Washington, DC 20010 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interva Physician failure. List only one cause on each line Between Onset and /Medical Death a Seizure Disorder Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): h Ohronic Alcoholism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and sician/Medical g physician a the burial - t UNPENDED 28a-f. perME.G876, 2/11/08 TT PTT The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year signed by the attending be detached for use as t Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown a Unknown Phy 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 V No 3 Probably 4 Unknown Chronic alcoholism; old brain contusions Completed of Vital Records, has been s 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? page 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) To the Hospital or Attending Physician; within 24 hours after death. 25. Was case referred to medical Be examiner? Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 this 1 🗸 Yes No 28c. Injury at Work?unk After 27. Manner of Death 28a. Date of Injury (Month, Day, Year)unk 28b. Time of Injury 28d. Describe how injury occurred 11nk Certification unk Division Yes 2 No 5 Pending To the Funeral Director: in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. unk 28f. Location (Street and Number or Rural Route Number, City unk or Town, State) 3 6 X Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sitinature and title of certifier O.C.M.E. January 13, 2008 and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

Registrar

**ORIGINAL** 

32. Registrar's Sign

Dire permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Physi /Med Exam

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760,

Registrar

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2		30. Name and address of person v	who completed cause of d	eath (Item 2	3a) (Type, I	Print) TS ROAD	, CLIW	70N, M	ARYZ	MWD	ر م2	735	_
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36	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther then "naturel", or items 23s or 28s-f show of other then "naturel", or items 23s or 28s-f show event, the Medical Examinar must be notified at	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 😭 Divorced	lf Yes 2 ∑ If Yes, Give Year or Dates	No		1 🗆 Yes	280 No	Specify:				Specify: p.1	ack	
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<u>ч</u>	that the		Part II. Other significant condition	Is contributing to death	but not res	sultina in the u	ınderivina	cause dive	en in Part I.		23e, Did	tobacco i	use contribute t	o the cause of death?	
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Ö	w req	lete									24a. Was		24b. Were a	utopsy findings available completion of cause of	9
He	The lay	mo									auto perf 1 ☐ Yes	ormed?			
ita	Physician: The this certificete ha al director, page	Bec	25. Was case referred to medical examiner?							of Death	Check only				-
5	Physic this co	은	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpat		ER/Outpatier			4 Jan Nu				6 □Other (Spe	ecify)	
<u>_</u>	ding i h. After funer	tlon	27. Manner of Death  1 ■ Natural 5 □ Pending 2 □ Accident investiga		Jury Jay Year)	28b. Time o Injury	м	28c. Injury Work	/aτ k? Yes 2⊡:		28d. Describe	now inju	ry occurred		
181	Attendir death.	flca	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place of I	njury - At h	ome, farm, st								lural Route Number,	
á	s afte	Certification:	4  Homicide determin	building,	etc. '(Specif	(Y)					City or To	wn, State	9)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Attenthis certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (	29a. Certifier 1 Certifying (Check only one)	Physicien: To the best xaminer: On the basis and manner:	of examina	owledge, deat ation and/or in	h occurre	d at the tim n, in my op	ne, date an pinion, dea	d place, a	and due to the ed at the time	cause(s , date <i>a</i> nd	) and manner a d place, and du	s stated. e to the cause(s)	
	vithin omple	Me	29b. Signature and title of certifier				29	c. License	e number	<u></u>		29d. Da	te signed (Mon	th, Day, Year)	_
•	- > = 0		+ Von	$(\mathcal{L})$				D 5	1521	0		0	1-22-	2008	
	6		30. Name and address of person w	no completed cause of	death (Iter	п 23а) (Туре,	Print)								
			Bahram Pishda		arlb	oro J	ike	For	rest	vill	e, Md	. 20	747		A00
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 3 0 2	2008 32 Regis	trars Sign	Ture	wells!								
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			State of Mary	•	artment of F			21	008	02378
ĸ			Registrar  1. Decedent's Name (First, Middle, Last)		Timodic or i	Death	2. Date of Dea	Reg. No. 4		3. Time of Death
	Physicia	_	Ronald Pinheiro				JAMUA	Day	2008	1342 M
	/Medic Examin	100	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Dea			nty of Death	
			University of Maryland			more,	MD			
	Funeral		100	n yrs. last birthday	If Under 1 Year   Months   Days	If Under 24 Hrs Hours Min		y, Year)	Country	ce (State or Foreign
li	Director		151–28–5936 X Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z	58 Yrs.			MAY 23,	1939	NEW .	JERSEY
	land ow			c. City, Town or L	ocation				10d	I. Inside City Limits
	with the Maryland a or 28a-f show be notified at	ţŏ	MD CAROLINE	DENT	EON					1 □Yes 2XNo
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	th wil		8000 LAUREL LANE		216				SA .	
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dikal Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. R	ace - American lack, White, etc	
36	s afte	by F	1 ☐ Never Married 2 【 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Spec	cify: WHIT	E
2-0036	tural		15. Decedent's Education	16a. Dece	edent's Usual Occup	ation		16b. Kind of	Business/Indu	stry
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7	filed within Hygiene, ther than "	Completed	12 2	SAI	LES ENGINE				FACTURI	NG
D	~ 0 9	Be	17. Father's Name (First, Middle, Last)				me (First, Middle,		ame)	
<u> </u>		2	HENRY PINHEIRO	405 14-7	·		MARCHESI		04-1-7-0	
Maryland 2	2 s		19a. Informant's Name/Relationship (Type. Print)  CATHERINE A. PINHEIRO/WIFE		ing Address (Street  O LAUREL					oae)
	1 an Heal em 2 ther			20b. Place of Disp	osition (Name of	1	Date		n - City or Tow	n, State
<u>o</u>	g = ;		1 ☐ Burial 2 <b>X</b> Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other ( <i>Specify</i> )		ematory or other place	1	1/16/200	ንይ ሮሞሞ	TRNCVII	TR MD
Baltimore,			21. Signature of Funeral Service Licensee	- 2	22. Name and Addre	ss of Facility				
ñ	permit. Departi Importi any inj		JOHN Z. MERCER	2002	FELLOWS, I 200 S. HAI	RETERNRE SETENRE	IN & NEWI T EASTON.	NAM FUR . MD 21	NERAL HO 1601	OME PA
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						, i	Approximate nterval Between
	Physician	21 2	Immediate Cause (Final disease or condition	hact	evenio					onset and Death
	/Medical	Ċ,	resulting in death)  Due to (or as a co	onsequence of):						- oury
	Examiner		Sequentially list conditions, b. Due to (or as a c		monia					1 days
	pe; set	nine	If any, leading to immediate Due to (or as a conclusion cause. Enter Underlying Cause (Disease or injury	onseguence or):						ı
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Õ	tificate ig phys as the	ledi								
X R R	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2		□Ectopic pregnance	V			Date of delivery Month D	yay Year
о П	0 0	sici	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown    1 □ Yes 2 □ No 9 □ Unknown	ne of death 5	Other (specify)				MOTAL D	ay real
J.	The law requires that the de tte has been signed by the e bage 2 should be detached t	Phy	Part II. Other significant conditions contributing to death but n	not resulting in the	underlying cause giv	en in Part I.	23e. Did to	obacco use co	ontribute to the	cause of death?
ds,	signe d be	l by			, , ,		1 🗆 '	res 2 □ No	3 ☐ Probal	oly 4 Unknown
Ö	w require been sign	etec					24a. Was	an 24	h Wara autons	ev findings available
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Vital Records,			25. Was case referred to medical			26. Place of De	1 Yes eath (Check only o	ne)	1 □ Yes 2	No No
	hysician: this certific al director,	To Be	examiner? 1 Yes 2 No Hospital: 1 Impatient	2 ER/Outpatie	ent 3 DOA Oth	or:	Home 5 ☐ Resid		Other (Specify)	
ō	ding Ph J. After th funeral		27. Manner of Death 28a. Date of Injury 1 ☑Natural 5 ☐ Pending (Month, Day You	(ear) 28b. Time		ry at rk?	28d. Describe I	now injury occ	curred	
0	endir eath. or: Ar	atic	2 Accident investigation			Yes 2□No				· · ·
Division or	or Att	Certification:	3 Suicide 6 Could not be 4 Hace of injury building, etc. (€	<ul> <li>At home, farm, s</li> <li>Specify)</li> </ul>	treet, factory, office		28f. Location (8 City or Tox	Street and Nu vn, State)	mber or Rural i	Route Number,
	pital		29a. Certifier 1 ☐ Certifying Physician: To the best of n	nv knowledge, dea	ath occurred at the ti	me, date and pla	ce, and due to the	cause(s) and	manner as sta	ted
3	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated	camination and/or i						
	To th within To th compl	Me	29b. Signature and title of certifier		29c. Licens	se number		29d. Date sig	ned (Month, D	ay, Year)
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	3		30. Name and address of person who completed cause of deat	h (Item 23a) (Type	e, Print)	2 . /				
			3. Montgomery 22 S	. Gyeev	re St.	Baltin	nove, h	10	21201	
	Sta Registi		31. Date filed (Month, Day) Year) 32 registrar's	By A	and)					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** PAULINE PARTON JANUARY 11:10 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RANDAULSTO UN HOSPITAL NORTHWEST Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year | 10.02 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Apr 1, Director 241 28 7314 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d Inside City Limits item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 9773 Groffs Mill Drive Apt 301 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc ☐Yes 2 🛣 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates: Specify: 2 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Licensed Practical Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guy K. Coon Ruby Barnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a Lynda P. Rotter/Daughter 136 Disney Court Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or or 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Ardent Crematory 1-15-2008 | Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CEREBROVASCULAR ACCIDENT disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Vear 4□Pregnant at time of death 5 Other (specify) ned by the a Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2,⊠₩6 Division or Vital 1∐ Yes 2 **⊠**0No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 270 No 1 🔲 Yes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After ' Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier ECCUTIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

MIRCEA TOBOR 31. Date filed (Month, Day, Year) JAN 1 6 2008

NORTHWEST 32. Revistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL SUOI OLD COURT READ DANDALLSTOWN MD 21133

D54355

MINCE A TODOR

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** PULLEY 2008 11:14 AM RENEE JANUARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLES COUNTY LA PLATA C-VISTA HOSPITAL LAPLATA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, JULY 20 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days Hours 1 M 2 F WASHINGTON, DC 1951 56 Director 577-68-8229 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County or items 23a or 28a-f show aminer must be notified at 1 ∏Yes 2 ☐ No Director CHARLOTTE HALL MD CHARLES 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number should be filed within 72 hours after death with and Mental Hygiene. 20622 USA 14010 ARNETTE PLACE Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify BLACK ģ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) other than Elementary/Secondary (0-12) U.S. MARSHALL GOVERNMENT 2YRS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental ROSA L. MORGAN MELVIN RUSSELL WILLIAMS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an 14010 ARNETTEPLACE CHARLOTTE HALL, MARYLAND 20622 SAMUEL PULLEY/HUSBAND Health tem 27 Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If It
any Injury or o 1 TBurial 2 ☐ Cremation 3 ☐ Removal from State MD VETERANS CEMETERY 1/23/2008 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Lice 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** METASTATIC BREAST CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2 No 9∏Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes 2 ☒ No this certificate 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1x Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours ancer con he Funeral Director: / death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D65304 JANUARY 15, 2008 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3510 OLD WASHINGTON ROAD WALDORF, MARYLAND 20602 KANIKA HAMPTON M.D.

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

2008

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Alma Catherine Plummer 2008 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 48753 Saint James Church Road Lexington Park St. Mary's If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1□M 2XF Months Director 216-30-4533 10/04/1932 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified at 1 ☐ Yes 2 No Directo Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 48753 Saint James 20653 Church Road United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No þ Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Accounting Supervisor Telecommunications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be Warren Dunbar Cora Ridgell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20653 19a. Informant's Name/Relationship (Type. Print) Stuart Plummer/Husband 48753 Saint James Church Road, Lexington Park, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Brinsfield-Echols Cre 01/11/2008 Charlotte Hall, MD of meral Service 22. Name and Address of Facility 21. Signa Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer with Metustusis **Physician** Lung. 4 monte /Medical **Examiner** Seizure Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed the burial-transit CUB ه Due to (or as a consequence of): Box 68760, physician Physician/Medical as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death for use 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 m nths? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) P.0. 9□ Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an certificate has autopsy performe Hy Califilemin Division or Vital 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient မ 3□ DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending P within 24 hours after death. To the Funeral Director; After t Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide filled in 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) JAN 1 4 2008 Begistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh Patel, M.D.

22650 Cedar Lane Court, Leonardtown, MD

70062215

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			Please	Type or									_		
		For State Registrar		State o	of Maryl		•		Health a f <i>Death</i>	ınd Me	ental Hyg	giene Reg. No.	0000	02302	)
		1. Decedent's Nam	ne (First, Middle, I	.ast)							2. Date of Dea	ıth	6 W W	3. Time of Death	No.
Physici /Medic		Betty C	G. Pride	gen							Month January		, 2008	2229 M	
Examin	er	4a. Facility Name (i	-						, or Location o	f Death		1	County of Dear	_	
		Southern  5. Social Security N	n Marylan	nd Hospi		yrs. last birti		Clinto		04 Hrs T	8. Date of Birth		rince G	thplace (State or Foreign	_
Funeral Director		579-84-3	3069	1 ☐ M 2 💢 F	59			onths Day		Min.	(Month, Day	, Year)	Co	ch Carolina	
and w		Usual Residence o 10a. State	f Decedent 10b. County		10c	. City, Town	or Locatio	on						10d. Inside City Limits	$\dashv$
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	lor	MD	Prince (	George's		Seat F	leas	ant						1 ☐ Yes 2X No	
the notif	Funeral Director	10e. Street and Nu	mber				1	Of. Zip Code	1		<u> </u>	10g. Citi	zen of What Co	ountry?	-
3a ol	O	818 Book	ker Place	2					20743			USA			
ms 2	ner	11. Marital Status		12. Was Dec		in U.S.	13. Was	Decedent of	f Hispanic Orig	gin? (Spec	cify Yes or No-		14. Race - Ame		_
after or ite mine		_	ried 2 Married	Armed Fo	2 X No			s, specily Ci Yes 2⊠N	uban, Mexican o <i>Specify:</i>	, rueito A	iican, eic.)		Black, Whit		
ours iral",	d by	3 🛛 Widowed	4 Divorced	Year or D									PT	ack	
"natu	lete	(Spe	15. Decedent's cify only highest of	Education grade completed)			(Give kind	's Usual Occ I of work dor VOT use reti	ne durina most	of working	g	16b. Ki	nd of Business	/Industry	
withir ene. <b>than</b>	Completed	Elementary/Seco	ondary (0-12)	College (	1-4or 5+)	Lat		Worke	•			May:	flower	Hote1	
filed Hygie ther	ပ္သ	17. Father's Name	(First, Middle, La	st)		Бас	111GL J	WOLING		r's Name	(First, Middle,				-
d be ental ked o c eve	To Be	Unknown	, , ,	,					Grac	e M.	Map1e				
shoul nd M	-	19a. Informant's N	lame/Relationship	(Type. Print)		19b.	Mailing Ad	ddress (Stre	et and Numbe	r or Rural	Route Numbe	er, City o	r Town, State, J	Zip Code)	
nd 2 alth a 27 is		Grace M.	Jackson	n/Mother		182	25 Ma	ry1ano	d Avenu	e NE	Washi	ngto	n, DC	20002	
of Heritan		20a. Method of Dis	'			b. Place of cemeter	Disposition	n (Name of ery or other p	lace)	Da	ate	20c. Lo	cation - City or	Town, State	
Page nent c int: If					State			-		1-22	-2008	Alex	andria,	VA	
permit. Departn Imports any inju		21. Signature of Fi	uneral Service Lic	ensee ///	2				tress of Facilit					Home, Inc.	
8 9 E 8 8	1	1	Mars	hall	_		421	7 9th	Street	, NW	Washi	ngto	on, DC	20011	
		23a. Part / Enter shock, or hea	the disease, or co art failure. List on	mplications that of	each line					cardiac or	respiratory ar	rest,		Approximate Interval Between	
Physician	9.9	Immediate Cause disease or condition	on	AG	ate My	in cardh	al In	Faretro	n					Onset and Death	
/Medical Examiner		resulting in death)  Due to (or as a consequence of):													
Examiner		Sequentially list conditions,  Due to or as a conservence of :											_		
sit ed	iner	cause. Enter Under Cause (Disease or	erlying	Due to	or as a cor	ise uence d	N1:								
executed in and ial-transit	Examin	that initiated event resulting in death)	s	c	(or as a cor	sequence o	nf)·								_
be exician	_				(		,-								
The law requires that the death certificate be execute the has been signed by the attending physician and bage 2 should be detached for use as the burial-trans	ğ			d											
certil nding use a	Physician/Medical	IF FEMALE: 23b. Was deceder	nt pregnant	23c. If yes, ou									23d. Date of de	livery	
death atte	cial	in the past 12	2 menths?		birth 2□ nant at time			opic pregna her <i>(sp</i> ec <i>ify)</i>					Month	Day Year	
the cy the achec	hysi	9 ☐ Unknowr		9□Unkn	iown										
s that ned t	by P	Part II. Other signi	ificant conditions	s contributing to d	leath but not	resulting in	the under	lying cause	given in Part I.		23e. Did to	bacco u	ise contribute to	the cause of death?	
quire en sig uld b	d b										1 🗆 Y	'es 2[	<b>∃</b> No 3□P	robably 4 □Unknown	- 1
aw re s bee 2 sho	Completed										24a. Was a		24b. Were a	utopsy findings available	
The late has	E O										autop perfoi 1□ Yes	rmed? 2 ☑ No	death?	completion of cause of 2 ☑ No	
fan: rtifica	BeC	25. Was case refe	rred to medical						26. Place	of Death	(Check only of		1 100		_
ding Physician: The lav n. After this certificate has funeral director, page 2 3	To B	examiner? 1 ☐ Yes 2 ☑	<b>Y</b> No	Hospital: 1 🗆	Inpatient	2 ☑ ER/Out	patient 3	B□ DOA C	Other: 4□ Nu	rsing Hom	ne 5 🗆 Resid	lence (	6 □Other (Spe	ecify)	
ng Pl fter th		27. Manner of Dea 1 ☑ Natural	th 5 ∐Pending	28a. Date (Mor	of Injury oth, Day Yea	28b. T	ime of njury	28c. In	jury at /ork?	2	8d. Describe h	ow injur	y occurred		
endii sath. or: A	ätic	2 Accident	investigat					M 1	☐ Yes 2 ☐ I	No		4,			
or Att ter de lirect	Certification:	3 ☐ Suicide 4 ☐ Homicide	determine	28e. Place	e of injury - <i>i</i> ling, etc. <i>(S</i>	At home, far becify)	m, street,	factory, offic	ce	28	8f. Location (S City or Tow	Street an n, State	d Number or R )	ural Route Number,	
spital or Atten ours after death reral Director: filled in by the						1		.1.20		140					_
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Medical	29a. Certifier (Check only one)	1 ☐ Certifying 2 ☐ Medical Ex	Physician: To the aminer: On the t	pasis of exa	r knowledge mination and	, death oco d/or investi	curred at the igation, in m	time, date an y opinion, dea	a place, a ith occurre	nd due to the e ed at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)	
To the Hos within 24 hd To the Fun completely	Med	29b. Signature and	d title of fatisfer	and mar	ner stated.			29c. Line	ense number			29d, Dat	te signed (Mon	th. Dav. Year)	-
F ≥ F 8	_	_ob. Dignature and	101					1			1		3.100 (1810)11	,,,,	

19 ye

Division or Vital Records, P.O. Box 68760,

State Registrar

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year)

JAN 1 5 2008 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print) where the same was a support of the same and address of person who completed cause of death (Item 23a) (Type, Print) when the same and address of person who completed cause of death (Item 23a) (Type, Print) when the same and address of person who completed cause of death (Item 23a) (Type, Print) when the same and address of person who completed cause of death (Item 23a) (Type, Print) when the same and address of person who completed cause of death (Item 23a) (Type, Print) when the same and address of person who completed cause of death (Item 23a) (Type, Print) when the same address of the same addr

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				Pleas	e Type or Prir					_			
			For State		State of Ma	arylan			Health and	Mental Hy	/giene	9	00001
		_	1 - State Registrar  1. Decedent's Name	(First Middle	(ant)		Cer	tificate of	Death	2. Date of D	Reg. No	2008	3. Time of Death
s <sup>2</sup>	Physici				J. Potts					Month	Da;		5:55 P M
	/Medic Examin		4a. Facility Name (If	not institution, g	give street and number)			4b. City, Town,	or Location of Deat			. County of Death	
	· · · · · · · · · · · · · · · · · · ·	1			c Living of			Snow 1				Worceste	
	Funeral Director		5. Social Security Nu 215-26-5		Sex 7. Ag	e (In yrs. 9	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bi (Month, D	ay, Year)	9. Birth Cou	place (State or Foreign ntry)
	fand bw it		Usual Residence of I	10b. County						10d. Inside City Limits			
	a-f sh	ष्ट्र MD Somerset Princess Anne											XXYes 2□No
	2 should be filed within 72 hours after death with the Maryland and Mental Hygene. Is marked other than "natural", or items 23a or 23a-f show aumatic event, the Medical Examiner must be notified at	al Director	10e. Street and Num		st Office R	d.		10f. Zip Code 218	53		10g. Cit	tizen of What Cou USA	ntry?
	ems 2	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.	.S. 13. W	/as Decedent of I	Hispanic Origin? (S can, Mexican, Puer	pecify Yes or N	0-	14. Race - Americ Black, White,	
036	ours after ral", or its Examine	by	1 ☐ Never Marrie 3 ☐ Widowed 4	21				□Yes XI No		is inoun, orany		Specify: Whi	
2	72 hc "natur	Completed	(Specif	15. Decedent's fy only highest of	Education grade completed)		16a. Decede	ent's Usual Occu	pation during most of worded)	rking	16b. K	ind of Business/In	dustry
[7]	within ene. than he Me	dmo	Elementary/Secon	dary (0-12)	College (1-4or 5	5+)		ectricia	,		St	ate of D	E
2	e filed Il Hygi other ent, t	Be Co	17. Father's Name (F	First, Middle, La	st) Potts				18. Mother's Nar		e, Maiden		
ylar	Menta Menta arked aric ev	To E	ETTIS	Carmar	1000				Paulin	e Malo	ne		
Baltimore, Maryland 21215-0036	ages 1 and 2 should to the stand Ment of Health and Ment It If item 27 is marked or orther traumatic etter		19a. Informant's Nar Richard	me/Relationship 1 Potts					t and Number or Ri Ave., Fru		-		o Code)
ore,	es 1 a of Hea fitem rothe		20a. Method of Dispo		☐Removal from State	20b. F	Place of Dispos cemetery, crem	ition (Name of atory or other pla		Date	20c. Lo	ocation - City or T	own, State
Ĕ	Pages tment of I tant: If ite		4 □ Donation	5 ☐ Other ( <i>Sp</i> e	cify)	Wio		Mem. Par				isbury, 1	
g	permit. Page Department of Important: If any injury or once.	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Bour 705 E. Main Street										1 Home ry, MD 2	1804
		23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.									arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (F disease or condition resulting in death)	inal	a. Cerek			ar f	facide	nl			2-3 WKS
	Examiner				Due to (or as	a conseq	uence or):						
×	p iti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) La	it initiated events C.									
2/60		_			d								
7 2 2 X	ertifica ling ph	Med	IF FEMALE:		00- 16								
POX	death of attended for us	Physician/Medica	in the past 12 n	nonths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 🗆 Feta	Ideath 3	Ectopic pregnand Other (specify) _	су			23d. Date of deliv Month	ery Day Year
7. Ö	at the by the tached	hys	9 Unknown		9∐Unknown								
	law requires that the death certificate seen signed by the attending phys should be detached for use as the	þ	Part II. Other signific	cant conditions	s contributing to death b	ut not resi	ulting in the un	derlying cause gi	ven in Part I.		tobacco i		he cause of death? bably 4 □Unknown
VItal Records,	aw req	Completed								24a. Was		24b. Were auto	opsy findings available
ř	The late ha	E O								auto perf 1∐ Yes	opsy ormed? 2 No	death?	mpletion of cause of 2□ No
VII	Ician: Sertific ector,	Be	25. Was case referre examiner?		Hoosital				26. Place of Dea				
0	Physic ruthis or ral dire	2	1 ☐ Yes 2 ☐ N 27. Manner of Death		Hospital: 1 ☐ Inpatie		ER/Outpatient 28b. Time of	3 □ DOA Ot	her: 4 Nursing H	lome 5 ☐ Res			fy)
0	nding tth. r: Afte e fune	ation	1 ☑Natural 2 ☐ Accident	5 ☐ Pending investigati	(Month, Da	y Year)	Injury	28c. Inju Wo M 1	rk? ]Yes 2∐No	200. DOGGINGO	now inju	19 00041104	
UIVISION	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine		ury - At ho	ome, farm, stre	et, factory, office		28f. Location City or To	(Street ar own, State	nd Number or Run	al Route Number,
	spital		29a. Certifier	Certifying	Physician: To the best	of my kno	wledge, death	occurred at the t	ime, date and place	e, and due to the	e cause(s	and manner as	stated.
	the Ho nin 24 h the Fu	Medical	one)		aminer: On the basis o and manner sta		tion and/or inv			urred at the time			
	Note that	2	29b. Signature and to	itle offcertifier				29c. Licen		a		te signed (Month, $-11-9$	* *
	JBN	-	30. Name and addre	S A R	O completed cause of d		AL, M 23a) (Type, P	(rint)	5442			11-2	000
			1604-1		et st.	Por	mark	· (1	4) 218	51			
	Sta		31. Date filed (Month	Day, Year)	2008 32. Redistr	ar's Signa	ture	free					
	Registr	ar		VIII. "	A		- "						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Jan 2008 5:00 AM 14 UNA MARIE OUICK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis HealthCare -The Pines Talbot Easton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
SEPT. 15,1919 6 Sev 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 X F Director MARYLAND 219-01-3265 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at TYes 2□No Director MD EASTON TALBOT 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 610 DUTCHMANS LANE 21601 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2X No þ Specify: 3**X** Widowed 4 ☐ Divorced WHITE Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12 0 OWN HOME Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MAXIMILLIAN WACHE IRENE WANGER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE F. KRATZ, JR./SON 1830 FOUNTAIN DR., UNIT 701, RESTON, VA 20190 20b. Place of Disposition (Name of cemetery, crematory or other place, GARDEN OF FAITH MEMORIAL GARDEN 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/18/2008 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 iZ. MERCERON CAMOL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** necemonia /Medical Due to (or as a consequence of): Examiner nation weeks Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner 10015 Due to (or as a consequence of) attending physician Physician/Medical as the IF FEMALE: signed by the attending t be detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 220No death? 1 □ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 30 No 1 TYes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 0

P.O. Box 687 Records, or Vital Division hours after death. within 24 hours at To the Funeral D Hospital

Registrar

29a. Certifier

(Check only one)

Medical

🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of d th (Item 23a) (Type, Print) G10

"UTCHMAN'S LANE

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

**JAN 1 5** 2008



		1 - For State Registrar	State of Marylar	nd / Depa	artme		ealth and	i Mental Hy		008	02386
Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last)     Betty Ann Rar     An Rar     An Rar  4a. Facility Name (If not institution, give s	nsburg treet and number)		4b. Cit	, Town, or	Location of De		Day 25,	Year 2008 unty of Death	3. Time of Death  1:00 P.M
Funeral Director		213-11-0323		last birthday) Yrs.	If Und Month	er 1 Year	minster If Under 24 F Hours M		rth	arroll  9. Birth Cou	place (State or Foreigr ntry) 1and
e Maryland 8a-f ehow	Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Frederic		ity, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 🙀 No
72 hours after death with the Maryland 72 hours of tems 23s or 28s-f ehow Jigal Exprignational be multified at	by Funeral Dire	10e. Street and Number  11310 Bottomley I  11. Marital Status  12 Never Married 2 Married 3 Widowed 4 Divorced	Road  2. Was Decedent Ever in Uarmed Forces?  1  Yes 20 No If Yes, Give Year or Dates:		Was Dec			(Specify Yes or N erto Rican, etc.)	Unite	of What Cou ed Stat Race Ameri Black, White, ecity: Whi	CES can Indian, etc.
within jiene.	Completed t	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	life.	kind of w DO NOT	ual Occupa ork done d use retired; orked	uring most of w	vorking	16b. Kind o	of Business/Ir	dustry
nould be filed Menfal Hyg narked othe	To Be (	17. Father's Name (First, Middle, Last)  Jacob Ray Ramsbur  19a. Informant's Name/Relationship (Tyx)	<u> </u>	T			Norma	Wright			
permit. Pages 1 and 2 should Department of Health and Mer Important: If ten 27 le marke ent injury or other traumatic once.		J.R. Ramsburg, Jr.  20a. Method of Disposition  1 Maurial 2 Cremation 3 Revenue 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licenses	/ father	1131 Place of Disponentery, cres	O Bo position (N matory or mete 2. Name	ttom1  ame of other place ry and Addres	ey Rd.	Rural Route Numb Thurmon Date /29/2008 eeney & F Street, F	at, MD 20c. Locati Thurs Basford	21788 ion - City or T	own, State Iaryland Ineral Home
Hiticate be executed / Medical Examiner  By physicien and as the burial-transit as the b	Jicai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the dea	th. Do not ent quence of): Do wall quence of).	ter the mo	de of dying	, such as card			CR, III	Approximate Interval Between Onset and Death
eath cer affendin for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	ac. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3	⊒Ectopic ⊒ Other (:	pregnancy specify)			23d	. Date of deliv Month	ery Day Year
w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying	cause give	n in Part I.		tobacco use		he cause of death? bably 4 □Unknown
ilcian: The law requirectificate has been rector, page 2 should	Completed							24a. Wa: auto peri 1 □ Yes	opsy ormed?	4b. Were auto prior to co death? 1 □ Yes	opsy findings available impletion of cause of 2  No
ng Phys fter fhis	on; To Be	25. Was case referred to medical examiner? 1	ospital: 1 Inpatient 2 I 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f	Othe 28c. Injury Work	r: 4 Nursing	Home 5 Res	idence 6		(y)
To the Hospitel or Attending within 24 hours after death of To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci		M reet, facto		′es 2 □ No		(Street and Nown, State)	lumber or Rur	al Route Number,
the Hospital in 24 hours the Funeral ipletely filled	edicai	one)	ician: To the best of my known:  er: On the basis of examination and manner stated.	owledge, deat ation and/or in	vestigatio	n, in my op	inion, death of	ace, and due to the courred at the time	, date and pla	ice, and due t	o the cause(s)
To t To t	W	29b. Signature and title of certifier  August 1996		m 22a) /Ti		Oc. License	number	14		igned (Month,	
Sta Registr		30. Name and address of person who con Stephen Sikorsk:  31. Date filed (Month, Day, Year)	M.D., 912 32 Registrar's Signa	Washin	gton		et, Wes	stministe	er, MD	21157	

DHMH 17 Rev 1/2001

			For State Registrar		State of Ma	ryland /		artment of F rtificate of a			Mental Hy	/gien Reg. N	00	08	02	387
	Physicia		1. Decedent's Name (Fin	irst, Middle, Last,	Rob	166	6 6				2. Date of De Month	D	ay	Year	3. Time of	Death M
	/Medic Examin		4a. Facility Name (If not			/ -	V / -	4b. City, Town, o	r Locatio	n of Deatl	01/1			of Death	10.	
			11138 OLD	WORTON I	RD.	WORTON							K	ENT		
	Funeral		5. Social Security Numb		7. Age	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Yrs. Months Days Hours Min.						rth a <i>y</i> , Yea	r)	9. Birthp		
Ь	Director		215-58-1930 Usual Residence of Dec	0	58 Yrs. 6/6/1949								9 AR			
	yland now at			b. County		10c. City, To	own or Lo	cation		-		10d. Inside City Limits				
	e Mar ka-fsk tified	ctor	MD K	ENT		WOI	RTON								1 ☐ Yes	2 <b>X</b> No
	or 28	Director	10e. Street and Number 10f. Zip Code 10g.											What Cour	ntry?	
	eath v is 23a must	eral	11138 OL		N RD.  12. Was Decedent E	vor in II S	21678		Origin? (S	nocify Voc. or N		USA  14. Race - American Indian,				
336	be filed within 72 hours after death with the Maryland ital Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married  3 ☐ Widowed 4 ☐	2 <b>X</b> Married	1 ☐ Yes 2 🟋 No			Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No <i>Specify</i> :					Black, White, etc.  Specify: WHITE			
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ano	tal d c	To Be	JOSEPH OLI								L MASON	, maide	n oaman	,,,,		
ary	d 2 should be th and Menta 7 Is marked traumatic ev	-	19a. Informant's Name/	/Relationship (Ty	pe. Print)	1	9b. Mailin	g Address (Street	and Nur	mber or Ru	ıral Route Numb	er, City	or Town,	State, Zip	Code)	
Ž	and 2 ealth a n 27 is		THOMAS ROB	INSON/HU	JSBAND			OLD WOR		RD.	WORTON,	MD	2167	8		
Baltimore, Maryland 21	of Her		20a. Method of Disposition 1 Warrial 2 Cro		lemoval from State	20b. Place ceme	e of Dispo etery, crer	sition (Name of natory or other plac	ce)	1	Date	20c. l	Location -	City or To	wn, State	
Ē	t. Pag tment tant: njury o		4 □ Donation 5 □	Other (Specify)		GALE		METERY		<u> </u>	8/2008	GAL	ENA,	MD		
E B	permit. Pag Department Important: I any injury o		21. Signature of Funera	Al Service Licensi Fullar	3		FF	Name and Addre LLOWS, H O SPEER	ELFE	ENBEL					IOME, I	PA
	87 — Al B		23a. PM1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													e ween Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	al ——	sS	UDI	DE	N C17	821	)1P	c pr	[7.	h		onot and i	
	Examiner			- 1	Due to (or as a	consequences	ce of):	AN A	1-1	20	Di	1 10	10			
	A 5 00	Jer	Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injury)	ons, diate	Due to (or as a	consequenc	ce of):	/						-		
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ŠĆ,	ficate be executed physician and is the burial-transit	EX	resulting in death) Last	- 1	Due to (or as a	consequent	ce of):									
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. Box	death cerl e attendin d for use	Physician/M	in the past 12 mon 1 Yes 2 No	nths?	1 ☐ Live birth 2 4 ☐ Pregnant at t			Ectopic pregnancy Other <i>(specify)</i>	/					onth	,	Year
J.	at the by th	hys	9 ☐ Unknown		9LlUnknown						T					
Ś	res t igne be c	þ	Part II. Other significan	nt conditions cor	ntributing to death but	t not resulting		iderlying cause give	en in Pa	rt I.					ne cause of d	
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UNISION	or At after d Direct in by	27. Manyer or Death  1 Natural  2   Accident  3   Suicide  4   Homicide  280. Imper or Death  1   Natural  3   Suicide  4   Homicide  280. Imper or Death  1   Natural  3   Suicide  4   Homicide  280. Imper or Death  1   Natural  3   Suicide  4   Homicide  280. Imper or Death  1   Natural  3   Suicide  4   Homicide  280. Imper or Death  8   Nork?  1   Yes 2   No  281. Location (Street and Number City or Town, State)										er or Rura	l Route Num	ber,		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1	Certifying Phys	 sician: To the best of	f my knowled	dge, death	occurred at the tir	me, date	and place	e, and due to the	cause(	s) and ma	anner as s	tated.	-
	n 24 h n 24 h he Fu pletely	edical	(Check only 2 one)	Medical Exami	ner: On the basis of and manner stat	examination ed.	and/or in	estigation, in my c	ppinion, o	death occu	urred at the time	, date a	nd place,	and due to	the cause(s	)
	Vithi To t	Ž	29b. Signature and title	of certifier	VQ			29c. Licens	e numbe	er	,	29d. D	ate signe	d (Month,	Day, Year)	
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08-00365

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Janet Skinner 1-For State Amend item#28F, QACHD, per OCM. Certificate of Death 1/16/03, LIS 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day January 13, 2008 Year 1023 hrs Medical Examiner JANET LOUISE SKINNER 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Annapolis Anne Arundel Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Director MARYLAND 218-70-3618 08/25/1958 М 2 **X**F 49 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 1 Yes 2 No 28a-f show items 23a or 28a-f shoust be notified at once. CENTREVILLE **OUEEN ANNE** MD death with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code USA 21617 304 HOLLY STREET 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Funeral 14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc. 1 Never Married 2 Married Yes 2 X No 9 WHITE Widowed 4 XDivorced Yes Give Year Yes 2 X No specify: Specify. "natural", 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than MD 21215-0036 t. Pages I and 2 should be filed within tment of Health and Mental Hygiene. LAW OFFICES **PARALEGAL** 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ð LOUISE SPARKS WALLS Be JOHN WALTER SKINNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 448 RIDGEVIEW ROAD, BRIGHTWOOD, VA 22715 KATHRYN A. POTTER/ DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) other 1 XBurial 2 Cremation 3 1-18-2008 CHURCH HILL, MD CHURCH HILL CEMETERY Donation 5 Other Specify 21. Signature of Funeral Service Linensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Human K. Hallandon 408 S. I.TBERTY ST., CENTREVILLE, MD Fail 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart free Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Torso Injuries And Drowning Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examiner Cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDED UNPENDED ending physician use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✓ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? has been signed by 2 should be detache 至 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has death? performed? ✓ Yes 2 1 Ves No Hospital or Attending Physician: 24 hours after death 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Other<sub>4</sub> 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Inpatient this 1 V Yes No After 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: Subject jumped from a bridge into water Jan 13, 2008 0925 hrs Natura Pending Yes 2 V No l Director: ed in by the f 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number Surpl-Route Number, City 3 V Suicide Could not be or Town, State) Chesapeake Bay Bridge, <del>Conterville</del>, Md determined (Specify) Bay 4 Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 14, 2008 O.C.M.E. Tanul A s of person who completed cause of death (Item 23a) Pameia E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Mo

Registrar

gistrar's Signature

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			1 – For State Registrar	State of M	/laryland		artment of F		d Mental Hy	giene Reg. No. 2	ΩΩ	02380	
r			Decedent's Name (First, Middle, L.	.ast)					2. Date of De	- G	Year	3. Time of Death	
h	Physic /Medi		HELEN LOUISE	Jan			10:15 AM						
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of E							4c. County		L	
					THE PI				rs. 8. Date of Bi		albo	C ace (State or Foreign	
	Funeral Director		215–18–4221 Usual Residence of Decedent	1□M <b>X</b> F	86	Yrs.	Months Days	Hours M	n. (Month, Da	ay, Year) <b>22,1921</b>	Count	Country) MARYLAND	
	/land ow		10a. State 10b. County		10c. City, 7	Town or Lo	cation				10	d. Inside City Limits	
	Man a-f sh ifled	ż	MD TALBO	T		EAST	ON					1 X Yes 2 □ No	
	or 28	Director	10e. Street and Number		- 1		10f. Zip Code			10g. Citizen of	What Count	ry?	
	ath w	ral	610 DUTCHMANS I	ANE	21601					US			
36	be filed within 72 hours after death with the Maryland ntal Hygiene.  Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 ☒Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1  Yes 2 If Yes, Give Year or Dates	s? <b>X</b> No	1	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerio 1 ☐ Yes 2 ★ No Specify:			14. Rad Bla Specia	ce - America ck, White, e		
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	be filed tal Hygi d other event, ti	Be C	17. Father's Name (First, Middle, La	st)				18. Mother's N	lame (First, Middle	, Maiden Surnai	me)		
/lar	2 should be and Mental is marked aumatic ev	P P	ELI MILLER	E A. PAT	CHET								
Maryland			19a. Informant's Name/Relationship				ng Address (Street				, State, Zip	Code)	
	s 1 and of Health item 27		EDWIN L. SPURRY	SON	20h Plac		BOX 297,	BOZMAN,	MD 21612		Oit of To		
Baltimore,	0 0 1		20a. Method of Disposition 1		cem	etery, cre	natory or other plac	i i		20c. Location	•	·	
Ħ	# 두 다른 .		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		OLIV		METERY  2. Name and Addre		14/2008	ST. MIC	HAELS	, MD	
Ba	perm Depa Impo any i		Loseph 20 A	- /	C.F.SE	2   F]	CLLOWS, H OO S. HAR	ELFENBE	IN & NEW	NAM FUNE	RAL H	OME PA	
8760,	Physician // Medical Examiner physician and physician and the pruiel-transit the pruiel-transit physician and physician and physician and physician and physician phys	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Southfully list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hyps Duga (or a c. Affee	as a consequent as a consequen	nce of):  / / / / / / / / / / / / / / / / / /	archyty cardiomy generality	,,			-	Onset and Death Minuses  years  years	
P.O. Box 687	t the death certific by the attending p ached for use as	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 No 9 □ Unknown		2 Fetal de at time of deat	eath 3	]Ectopic pregnanc; ] Other (specify) _	/		23d. Date of delivery Month Day			
	w requires that the sbeen signed by the should be detached	by F	Part II. Other significant conditions		but not resultir	ng in the u	nderlying cause give	en in Part I.				e cause of death?	
orc	requi	sted	Dementia Hypothyro	1/244					-   10	Yes 2 □ No	3 Proba	ably 4 Unknown	
or Vital Records,	The la ate has page 2	Completed		-12011					24a. Was - auto perfo 1 Yes		prior to con death?	osy findings available opletion of cause of 2 No	
VIE V	Physician: The rhis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		eath (Check only				
0	Phys r this ral dir	은	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of In		l/Outpatier Bb. Time o		4 Mursing	Home 5 Res	idence 6 Otl		)	
Division	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral direction.	Certification:	TMNatural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	on be 28e. Place of in	Day Year)	Injury	Worl	yes Yes 2 □ No		Street and Num		Route Number,	
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier (Check only one) Certifying F	Physician: To the bes aminer: On the basis and manners	of examination	edge, deat n and/or in	n occurred at the tirvestigation, in my o	me, date and pla opinion, death o	ace, and due to the ocurred at the time	cause(s) and m	anner as sta	ated. the cause(s)	
)	To t with To t	M	29b. Signature and title of certifier	Yeon lan,	M		29c. Licens	25933	3	29d. Date signe	3.08		
	3	ate	30. Name and address of person when MICHREL RO	JULLY M	death (Item 23	610	DUTCHI	man's	LANE	EASTO	N, MI	1 21601	

State Registrar

32. Registrar's Signature

DHMH 17 Rev 1/2001

# State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month JEFFREY B. SCHALL JANUARY /Medical 8 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 25846 ROYAL OAK ROAD NEWCOMB If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**X** M 2 □ F Director 218-58-0311 51 AUG 8,1956 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notified at Director MD TALBOT NEWCOMB 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25846 ROYAL OAK ROAD 21653 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No Specify: <u>ک</u> Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 is marked other this any injury or other traumatic event, the once. 10 CARPENTER HOME CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RAYMOND E. SCHALL, SR. SARAH EASON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAMELA SCHALL/WIFE PO BOX 86, NEWCOMB, MD 21653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SPRING HILL CEMETERY 1/12/2008 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 Joseph M. Ostrously 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** rade aliobastoma multiform nia /Medical Due to ( s a consquence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hypothyroidism Completed

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 After this 124 hours after death.

Pe Funeral Director: A pletely filled in by the fu

Be

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Certification:

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4 ☐ Homicide 29a. Certifier (Check only one)

1 ✓ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

D6059939

29d. Date signed (Month, Day, Year)

Year

TALBOT

12:40PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

Year

1 ☐ Yes 2 X No

MARYLAND

2008

USA

Black, White, etc.

WHITE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Easton Family Physicians 508 Idlewild

32. Restrar's Signature 1 2008

Egglert, MD

State

0

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Day Year -ouise Javille 2008 8:52 AM /Medical Junuary County of Death 4a. Facility Name (If not institution, give street and number) 4c. County of I 4b. City. Town, or Location of Death Examiner Community Hospital Lanham If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months 1 M 2 F Director 12-18-1421 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside Offy Limits 1 XYes 2 No Director Angeles Angeles 125 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 10 900 43 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ ₩6
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Black Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) aker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be nown ပ္ rac Informant's Name/Relationship (Type. Print, 19b, Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) atrice Javille Mitchellville 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Kiverdale 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 6. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause and line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1 ☐ Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27, Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day Vear) 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed

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After this certificate

To the Funeral Director:

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Attending Physician:

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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

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Item 27 is marked other than "natu other traumatic event, the Medical

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau

Examiner

r 28a-f show notified at

15 State Registrar

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print) Luck Road

8118 Good Abdulwa

31. Date filed (Month, Day, Year 6

29a. Certifier

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32. Registrar's Signat

Division or Vital Records, P

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To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) 14285 1-22-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. William D. Boyd, II 25365 Pointlookout Road, Leonardtown, Maryland 20650 31. Date filed (Month, Day, Year) istrar's Signature State

State Registrar

JAN 2 2 200



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 6:00 Louise Marie Stack January 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 24496 Joy Chapel Lane Hollywood St. Mary's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7, Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) August 12,1925 9. Birthplace (State or Foreign Country) District of Columbia Funeral 6. Sex Months Days 1 ☐ M 2 🗓 F 82 215-84-8863 Director Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits show . 28a-f sh notified 1 ☐ Yes 2 🗓 No Director Maryland St. Marv's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. and 11 steller 21 is marked other than "natural", or items 23a or 1 ury or other traumatic event, the Medical Examiner must be tury or other traumatic event, the Medical Examiner must be to 24496 Joy Chapel Lane 20636 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Solomon Andrew Sweeney Mary Louise Howard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cleone Marie Wible / Daughter 24496 Joy Chapel Lane, Hollywood, Maryland 20636 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important; If ite any Injury or ot once. 1 X Burial 2 □ Cremation 3 □ Removal from State Charles Memorial Gardens 4 Donation 5 Dother (Specify) 25, 2008 Leonardtown, Maryland 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licenses P.O. Box 270, Leonardtown, Maryland 20650 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCIERUTIC CARDIOVASCULAR Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, warry, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical JE FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Dav Year signed by the a d be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9☐Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should t 1 ☐ Yes 2 - No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy
performed?

1 Yes 2 100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1√0 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: At completely filled in here. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division or Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJISI NIDGE

29a. Certifier

(Check only one)

Medical

State

Registrar

31. Date filed (Month, Day, Year) JAN 2 3 2008

29b. Signature and title of certifier



ASCOCITIES

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 16096

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29d. Date signed (Month, Day, Year)

20636.

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Calvin	Spruill

Calvin Spruill		State 1- For State Registrar	of Maryland /		tment of He ficate of De		Mental		leg. <b>N</b> o.	200	08 0239
Physicia	n/	1. Decedent's Name (First, Middle,Las	t)					2. Date of Dea	ath Day	Year	3. Time of Death
Medical Examin		Calvin Spru 4a. Facility Name (if not institution, giv	i11		Ta s	the Territor	nosti : C	January 2	20, 2008	3	0930 hrs
		2096 Lake Grove Lane			Cr	ity, Town, or Lo			An	County of Deat ne Arunde	
Funeral Director		5. Social Security Number 6. Social Security Number 1X		(In yrs. lasi 21		Under 1 Year onths Days	If Under 24 Hours	4Hrs. 8. Date of Bi Min. August	rth(MM/DI	D/YYYY) 9. Bi Forei 1986 Cc	rthelace (State or grives as nington, puntry) DC
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arylan at onc	Funeral Director	10e. Street and Number	Idilibia	Wab	-	. Zip Code			10g. Citize	en of What Cou	21.
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h with	era	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was De	cedent of Hispa		(Specify Yes or Nuerto Rican, etc.)			rican Indian, Black,
r death	티	1 X Never Married 2 Married	1 Yes 2	X No				ierto rican, etc.)			
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2 hour	Ę	Elementary/Secondary (0-12)	College (1-4 or 5-		during most o	f working life. [			TOD. I'di	id or business	, madali y
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Shoul and N. 7 is m	ို	Calvin Spruill,								or rown, Stat	e, ∠ip Code)
and 2 realth item 2 traum		20a. Method of Disposition			ace of Disposition	(Name of ceme	etery,	ria, VA 2	20c. Lo	ocation - City o	r Town, State
Baltimore, MD 21215-0036  Permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28n-f show any injury or other transmatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify	:	e Lin	ematory or other p	Cemete	ry J	an 28, 20	8 0	Suitla:	nd, MD
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Division of Vital Records, P.O. Box 68760, rial or Attending Physician: The law requires that the death certificate be executed are after death.  All Director: After this certificate has been signed by the attending physician and lited in by the funeral director, page 2 should be detached for use as the burial - transit	l Examiner	events resulting in death) Last	Due to (or as a consec	quence of):							
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of Vi Physicerthis	욘	1 Yes 2 No 27. Manner of Death	impatien		R/Outpatient 3			lursing Home 5 28d. Describe	_		er: Scene
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Div ital or urs aft	Certification:	Suicide 6 XCould not determine	at an area of	ouse				2096 Lak	state) e Grov	re Lane (	Crofton, MD
	Medical C	Chidak chiy	ian: To the best of my	-				, and due to the car	use(s) and	manner as st	ated.
To To con	Med	29b. Signature and title of certifier	and manner stated.	·	<del></del>	29c. License	number		29d. D	ate signed (M	lonth, Day, Year)
		Mayaire M	re Viell			O.C.N	1.E.		Janu	ary 21, 20	08
		30. Name and address of person who Margarita Korell MD. A	completed cause of de ssistant Medical E	•	,	Street, Ba	Itimore, N	MD 21201			
Sta	_	31. Date filed (Month, Day, Year)	32 Registrar	s Signature	AND AND						
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	Dharisi		Decedent's Name (First, Middle, Last)						Date of Death Month	1	'ear	3. Time of Death		
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20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ▼ Divorced	<ul> <li>12. Was Decedent Ever in U.S Armed Forces?</li> <li>1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:</li> </ul>		Was Decedent of H f Yes, specify Cub 1 □ Yes 2 No	Hispanic Orig an, Mexican, Specify:	gin? (Specify , Puerto Rica	Yes or No- an, etc.)	14. Race - Black, Specify:	White,	etc.		
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Š.	Director	-	219-34-6313 Usual Residence of Decedent		69 Yrs.						June	e 20 <b>,</b>	1938	MD			
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saitimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Li	ensee	10	Dever	22.	Name and Ad	dress of				ral l	Home In	nc.		
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X Q Q	death certifica attending ph I for use as th	ian	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)								23d. Date of delivery Month Day				Year		
л Э	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as:	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unk		e or dealir	J	Other (speary	/								
	s that ned by deta	by Ph	Part II. Other significant condition	s contributing to	death but no	ot resulting in	the un	derlying cause	given in	Part I.	23	3e. Did tob	acco use	contribute to	the cause of d	leath?	
VITAI HECORDS,	quire en sig uld be	q pa									_	1 ☐ Ye	es 2	No 3□Pro	bably 4 L	Jnknown	
000	law re as bee 2 sho	plet									24	ta. Was ar	1	24b. Were au	topsy findings a	available ause of	
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<u> </u>	Physician: r this certific ral director,	Be (	25. Was case referred to medical examiner?	Hospital:						Place of E	Death (Che	ck only one	9)				
0	Physi this c	٦ ا	1 ☐ Yes 2 No  27. Manner of Death	1 1 1	Inpatient te of Injury	2 XER/Out		3 DOW		I ☐ Nursing		Reside		Other (Spec	sify)		
	iding Physician: th. After this certifica	tion	1 Natural 5 Pending 2 Accident investiga	(Mc	onth, Day Ye		jury		njury at Vork? □ Yes	2 □No	200. 5	0001100 110	ir injury c	30001100			
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	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Medical (		Physician: To the xaminer: On the and ma		amination and										s)	
# E # D P 29b. Signature and title of certifier 29c										mber		29	9d. Date s	signed (Montl	, Day, Year)		
)			Nonso	ch St	mi	MI	9		000	553	325		Jan	25,	2008		
	4		30. Name and address of person w						20		d mic i	4 4 1 2		. د حواد د			
	\		31. Date filed (Month, Day, Year)	EN 43	Registrar's	Signature	W	ALSH Y	< D_	CUM	BERL	ANJ)	140	2150	_		
	Sta Registi			2008	Thousand S	Signature	000										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 24, 2008 Physician 4:10 P M January Marian Alice Tasky /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner <u>Riverview Care Center</u> Baltimore Birthplace (State or Foreign Country) Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Age (In vrs. last birthday **Funeral** Year) Months Days Hours 1 □ M 2**∑** F 82 Sept. 18, 1925 Ohio Director 287-22-9913 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11803 Point Way 20720 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 27 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Specify.White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygienn Important: If item 27 is marked other this any lijury or other traumatic event, the once. 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Sund Ellen Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11803Point Way, Bowie, Maryland 20720 ace of Disposition (Name of Date 20c. Location - City or Toy James Tasky/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-30-08 | Twinsburg, Ohio CrownHillMem.Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. muchace 6009 Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** year /Medical Due to (or as I o nsequence o) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed nding physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No reral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

JAN 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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32. Registrar's Signature

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			For State						artment of			fental Hy	giene		
			Registrar An		b, perME,g	376,	2/28/08	Trei	tilicate o	Del	<u> </u>	2. Date of De	Reg. No.	08	3: Time of Death
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7.3	/Medic Examin		4a. Facility Name (/						4b. City, Town	n, or Loca	ation of Death	O I I I I		ty of Death	1.00 1
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diferen	Director		Usual Residence of				J4					MAI 23	1900		
	arylan show	_	10a. State	10b. County			10c. City, To	wn or Lo	cation						10d. Inside City Limits 1√□Yes 2□No
	he Ma 28a-f s	Director	MD		E GEORGE	' S	F	ORES	TVILLE				10g. Citizen of	What Cou	
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at	Ö	10e. Street and Nu		ON STREE	г			10f. Zip Cod	。 0747	7		USA	Wilat Ood	nuy:
	death ms 23	Funeral	11. Marital Status		12. Was De	cedent	Ever in U.S.	13.	Was Decedent of If Yes, specify C			ecify Yes or N		ace - Americ	
٥	after or ite		1 X Never Marr		Armed I ed 1 ☐ Yes If Yes, ( Year or	2 <b>K</b> 11	No		ir res, specily C 1 □ Yes 2 <b>X</b> □N		oecify:	nican, etc.)	Spec	ack, White, ifv: RT	ACK
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ž.	requires that the een signed by th hould be detache		Part II. Other signi	ficant conditio	ns contributing to	death b	ut not resulting	g in the u	nderlying cause	given in	Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?
g	quires an sign uld be	ed by							,			1 🗆	Yes 2 No	3 ☐ Pro	bably 4 ☐Unknown
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UIVISION	or Atter ter de irecto n by th	Certification:	3⊉ Suicide 4 ☐ Homicide	6 🗌 Could n determi	28e, Pla	ce of inj iding, et	ury - At home, c. <i>(Specify)</i>	_	reet, factory, offi	ce		28f. Location City or To	(Street and Nur own, State)	nber or Ruj	ral Route Number, WALKER Trict Height
ב	pital o		29a, Certifier	1 Dertifying	g Physician: To t	ha hast	of my knowled		th occurred at th	e time o	tate and place	11	17/11/6		- 7
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Registrar

State

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8600 Old Georgetown Rd. Bethesda, Md.20817

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Michael Jach, M.D.

31. Date filed (Month, Day, Year)

JAN 1 6 2008

Raymond J. Van	_	O S	ate of M	laryland		rtment of			d Menta	al Hy	giene		0	0.0	0 0	01.0
Dhysicia		Registrar  1. Decedent's Name (First, Midd	le Last)		Cer	tificate of	Deat	7			2. Date of De	Reg. No		UIJ	3. Time of Dea	<u> </u>
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_		Fort Washington Med	lical Cente	er			Fort \	Vashin	gton				Prince G			
Funeral		5. Social Security Number	6. Sex	7.	Age (In yrs. Ia	ast birthday)		er 1 Year s Days	_	24Hrs. Min.	8. Date of	Birth (MM	I/DD/YYYY)	<ol><li>Birth Foreign</li></ol>	APESSIPE	-
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any	ŀ	Usual Residence of Decedent 10a. State 10b. County		-	10c. City,	Town or Locati	on								10d. Inside Cit	ty Limits
	ايا	Maryland Princ	e Geor	ge's	For	t Washi	ingto	on							1 X Yes 2	No.
faryfar 28a-f	Director	10e. Street and Number			l		10f. Zip	Code			-	10g. Ci	tizen of Wh	at Coun	try?	
a or		401 Taurus Dr	ive				20	744				Uni	ted S	tate	es	
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5-0036 led within 7 Hygiene. I other than	ם		4	vears	3	Cont	traci	t Nes	gotia	tor			Gover	nmer	nt	
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2121 2121 Mental be fi marked	o Be	Joseph Vanze 19a. Informant's Name/Relation	go	rint )		19b. Mailing	Addross	/64700	Be:	rtha	Shaw	lumbar	City of Tour	Ctato	Zin Code)	-
jimore, MD 21215-0036  Pages I and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Iant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	F				:_								•		,	
e, N I and I Health item	H	Margaret A. Va 20a. Method of Disposition			20b. F	1401 Ta	ition (Nar	ne of cen	netery,	OFL	Date Date	200	Location -	City or	7 4 4 Town, State	
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4		30. Name and address of perso	\		of death (Item	1 23a)										
,		Ling Li, MD Assist	ant Medica	al Exami	ner 111	Penn Stree	et, Balti	more,	MD 2120	01						
St Regist	ate	31. Date filed (Month, Day Year	6.	32. Regis	strar's Signatu	back										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** William Joeseph Wheeles 25, 2008 January 11:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6950 Rooks Court, Apartment 103 Frederick Frederick 8. Date of Birth (Month, Day, Year) January 21, 1931 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Oklahoma 1**X** M 2□ F 77 559-44-8781 Director Usual Residence of Decedent 10c. City, Town or Location 10h County 10d. Inside City Limits show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 ☑ No Maryland Frederick Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21703 6950 Rooks Court, Apartment 103 United States ral", or Items 23a Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyles 2 □ No 1948 ■ 17 Ps, Give Year or Dates: 1968 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced White "natural", 1968 Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than Civil Service Federal Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Mental } Pennington Lane Wheeles Is marked Bessie Edna Correy ပ of Health and Nitem 27 Is mai 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty C. Wheeles / Wife 6950 Rooks Court, Apartment 103, Frederick, Maryland 21703 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite January 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory Smithsburg, Maryland 28, 2008 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 East Church Street, Frederick, MD 21701 21. Signature of Funeral Sprvice Licenses M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA **Physician** UNKNOWN disease or condition resulting in death) /Medical ue to (or as a consequence of): Examine CARDIO - VASCULAR RTERIOSCLEROTIC UNKNOWN Se uentially list conditions it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Box 68760,写 and Due to (or as a consequence of) burial-t the attending physician Physician/Medical the. as t IF FEMALE use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Dav 5 ☐ Other (specify) P.O. I ☐Yes 2☐No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ RTENSION 1 Yes 2 No 3 Probably 4 Onknown Completed CHRONIC OBSTRUCTIVE PULMONALY 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an has autopsy performed? Yes 2 (No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 AResidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) determined 4 Homicide ō To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

MEDICAL DIRECTUR: 516 TRAIL AVE;

D10587

29d. Date signed (Month, Day, Year)

HUSICE OF FREDERICE COUPTY

JANUARY 26, 2008

			For State Registrar	State of Ma	aryland /		urtment o <i>tificate d</i>				giene Reg. No.	2008	0240
F	Physici	3	1. Decedent's Name (First, Middle, La	ast)						2. Date of De	eath Day	Year	3. Time of Death
	/Medic		Dolores O. W							Janua	ry 1	6,2008	2:58p <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, gi				4b. City, Tow		on of Death		4c. C	County of Death	
		5 L.	Union Hospita  5. Social Security Number 6.		e (In yrs. last t	nirthday)	E1 F	ton	der 24 Hrs.	8. Date of Bir	th	Ceci	
Ľ	Funeral Director			1 □ M 2 🔀 F	95	Yrs.	Months Da	ys Hou		(Month, Da	4,19	12	place (State or Foreign ntry)  PA
			Usual Residence of Decedent		40. Oit. T-								
	with the Marylan a or 28a-f show t be notified at	'n	10a. State 10b. County		10c. City, To								10d. Inside City Limits 1   Yes 2   No
	the M 28a-f notifie	Director	PA Schuy	LK111	Pot	tsv	111e	10			10a Citiza	en of What Cour	
	3a or		640 Edwards	AVE.			179				U.S		,
	death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. V	Vas Decedent f Yes, specify (		Origin? (Spe	cify Yes or No		4. Race - Americ	
215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 N If Yes, Give Year or Dates:	10		Yes 2			rican, etc.)		Black, White, Specify: Wh	ite
Ş	"natur	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16	a. Deced	lent's Usual Od kind of work do OO NOT use re	cupation	nost of worki	na	16b. Kind	d of Business/In	dustry
7	d within 72 ho giene. r than "natu the Medical	m p	Elementary/Secondary (0-12)	College (1-4or 5-	+)						Gar	mont F	actory
7	filed v Hygie other t		17. Father's Name (First, Middle, Las			Sec	amstre		other's Name	(First, Middle			actory
Maryland 2	ed tal	To Be	James Garfie		er					Krebs	,	,,	
ar∠	SP E E		19a. Informant's Name/Relationship			9b. Mailin	g Address (Str				er, City or	Town, State, Zip	Code)
	1 and 2 Health a em 27 Is other trau		Dolores E. Lel	nman/Daug							11e,	PA 1	7901
Baitimore,	S = = 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from State			sition (Name on atory or other		Janu	ate		ation - City or To	·
	tment tant:		4 □ Donation 5 □ Other (Special	fy)			rown G L <sub>Na</sub> Ceme		1 22	2008	Ann	ville,	PA
a n	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lice	nsee	Maci	1	Andrew	G.	Gée F				
		$\dashv$	23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused	the death. Do	o not ente	259 E. er the mode of	Mai dying, such	n St. n as cardiac o	F1k or respiratory a	ton, rrest,	_MD2	1921 Approximate
	Physician	3 34	Immediate Cause (Final	one cause on each lin	e.								Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	a. Due to (or as a	a consequence								
	Examiner		Sequentially list conditions, b. Praymone, litt, abdominal Source										
1	sit sit	iner	ause. Closesse or injury hat initiated events  c.										
Ž.	and I-trans	Examin	that initiated events resulting in death) Last	c	consequence	e of):							
09/89	ificate be executed g physician and as the burial-transit	E E		`	•	,							
2Ω	ificate g phy as the	edical			-								
X Q Q	at the death certifii I by the attending petached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p		th 3	Ectopic pregna	anov			23	3d. Date of delive	,
ם כ	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at			Other (specify					Month	Day Year
٦.	at the	Phy	9 Unknown		ut mat vaaviltiam	in the con	dad isa a sa ca	aliana la Di		One Did A			he cause of death?
Š,	w requires that the s been signed by the should be detache	by	Part II. Other significant conditions	> $\Delta \lambda$	it not resulting		Cl. e.s.	given in Pa	anı. Lo li	23e. Dia 0			
cords,	v requ	Completed	B	7	<i>V</i> 5)	A 0	= -		2				
Ě	e la has	m D	- Drest	-cnc-		/+ 12	- (-	1000	12 - 2	24a. Was auto perfo		prior to co death?	opsy findings available impletion of cause of
VITA	ician: Th certificate rector, pag		25. Was case referred to medical	1				06.0	lage of Dogsth	1□ Yes	2 2 No	1 □ Yes	2 □ No
>	S ==	o Be	examiner?	Hospital: Inpatier	nt 2□ER/0	Outpatien:	3 □ DOA	Othor:		ne 5□ Besi		☐Other (Special	fv)
0	ding Phys h. After this funeral dir	$\vdash$	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b	. Time of Injury		njury at Work?		28d. Describe			,,,
VISION	endin ath. or: Af he fur	atio	Natural 5 Pending investigation	n	, 64,7	,,		1 ☐ Yes 2	2 □ No				
Ž	or Att ter de irect n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home, c. (Specify)	farm, stre	eet, factory, off	ice	2	28f. Location ( City or To	Street and wn, State)	Number or Run	al Route Number,
נ	pital yours a eral C		29a. Certifier • Certifying P	hysician: To the best o	of my knowled	ne. death	Occurred at #	ne time dat	e and place	and due to the	cause(e)	and manner as a	hatet
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examination a	and/or inv	estigation, in	my opinion,	death occurr	ed at the time,	date and	place, and due t	o the cause(s)
	To the vithin To the compl	Me	29b. Signature and title of certifier					ense numb			29d. Date	signed (Month,	Day, Year)
)			1 Mamile	a duli	mo		B	00	637	130	1/1	6/08	
			30. Name and address of person who	completed cause of de						- ·			
	12					~	HOSI	DITE	11, 1=	-1-12-	100	s, M.	0
	Sta Registr		31. Date filed (Month, Day, Year)	2008 32. Hegistra	ar's Signature		back ,						

DHMH 17 Rev 1/2001

		1- For Amend Item State of Maryland / Den 3 per dr., g8/6,02/e	16/08dhb rtificate of Death		J. No.	UZ9UJ
Physi	cian	1. Decedent's Name (First, Middle, Last) Mary Ellen Wilmer		2. Date of Death Month 1-5-2008	Day Year	3. Time of Death  2:15 p. M
Exan		4a. Facility Name (If not institution, give street and number) 321 Little Kidwell St.	4b. City, Town, or Location of Death Centreville, MD		4c. County of Death Queen Anne	e, MD
Funer		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 20-28-2531 1 M 25 F 92 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Y 8-26-191	'ear) Cour	lace (State or Foreign try)
P		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation			0d. Inside City Limits
r 28e-f sl	Director	Maryland Queen Anne Centrevil  10e. Street and Number	1e 10f. Zip Code	10g	g. Citizen of What Cour	1≹Yes 2□No
ath with \$ 23a o	raiD	P.O. Box 314	21617		JSA	and Indian
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28e-1 show eny injury or other treumetic event, the Mydical Expirition or the recumetic event, the Mydical Expirition or the recumetic event.	by Funerai	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, 2 Mo It Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Blac	etc.
21215-0036 d within 72 hours aff giene. er then "neturel", or the Medical Exami	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing	6b. Kind <i>o</i> f Business/In	
Id 27	Be Co	12 House 17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	House wife	
Maryland Id 2 should be file th and Mental Hy 27 Is marked oth treumetic even	ToB		Anna Tho			
Mar nd 2 sh lith and 27 Is m	9		ing Address (Street and Number or Rur Box 314 Centrevil		City or Town, State, Zip 2161 <b>7</b>	(Code)
Baltimore, permit. Pages 1 ar Department of Heal mportent: If item 3 ny injury or other		20a. Method of Disposition 20b. Place of Disposition 3 Removed from State cemetery, cre-		Date 20	Dc. Location - City or To Centreville	
Baltil permit. I Departm Importer	- Suce	21. Sig thur tureral Service Licensee	22. Name and Address of Facility	W Divis	sion St Do	ver, DE
		23a. Part. There the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres		Approximate Interval Between Onset and Death
Pnysicia /Medica Examine	al	disease or condition resulting in death)  a	Heart Fail	WC.		
10.70	e I	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Artery De	rease		9
8760, cate be executed physician and the burial-transit	dical Examin	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
Box 6 ath certifi	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown  IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	ery Day Year
cords, P.O. I w requires that the de been signed by the s should be detached it	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
Rec he taw has b ge 2 sl	Complete	Hyperkusicn		24a. Was an autopsy performe	prior to co death?	opsy findings available impletion of cause of
of Vital F Physicien: Th this certificate ral director, pag	o Be (	25. Was case referred to medical examiner?	Othor	h (Check only one)		£.1
on of sing Phy After this funeral d	- I I I	1 Yes 2 No respiral 1 Inpatient 2 ER/Outpatie  27. Manner of Death Vatural 5 Pending 2 Accident investigation  1 Inpatient 2 ER/Outpatie 28a. Date of Injury (Month, Day Year) 28b. Time Injury	AR GERGIT	28d. Describe how	ice 6 □Other (Special vinjury occurred	у/
Division of or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
Division  To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal (Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cau	use(s) and manner as s te and place, and due t	stated. o the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier Guanner D.O. Phys.	29c. License number Uan #60578		d. Date signed (Month,	Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type 2540 (ENNEXTIVE Road)	, Print) Vale ale	GOODIN	lan , Di	Ö
-	State strar	31. Date filed (Month, Day, Year)  32. Register's Signature	South			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY **Physician** 2008 Рм LEO FRANCIS WARNICK 9:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NATIONAL INSTITUTES OF HEALTH BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F 44 Yrs. 12-22-1963 Ohio Director 278-72-3511 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No **Funeral Director** Summit Norton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2952 Wayne Street 44203 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No \$ Specify: 3 Widowed 4 Divorced White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HVAC Technician Ohio Mechanical 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Foster Warnick Virginia Kerney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norton, OH permit. Pages 1 and Department of Health Important. If item 27 any injury or other troonce. Sheila Warnick/Wife 2952 Wayne Street, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 01-18-2008 | Akron, OH 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Cemetery 21. Signature of Fine al Service L 22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street, NW Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4 MABOLIC **Physician** /Medical Due to (or as a consequence of): Examiner MYCOSAGREIUM NIVM 155(m NATED if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed MODULATUR sician and burial-trans Due to (or as a consequence of) Records, P.O. Box 68760. physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.

The Funeral Director. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the learned on the search of the completely filled in by the funeral director, page 2 should be detached for use as the learned of the complete of the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 □ No Yes Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar 29a. Certifier

29b. Signature it title of certifier

30. Name and address of person

31. Date filed (Month, Day, Year)

2008 6

DHMH 17 Rev 1/2001

and manner stated.

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

0333

29c. License number

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

29d. Date signed (Month, Day, Year)

		1 - For State Registrar	State	of Marylan		artment of F rtificate of				giene Reg. No	200	8 02405
100	48	1. Decedent's Name (First, Middle,	Last)	_					2. Date of Dea	ath		3. Time of Death
Physic /Med		Catherine	Wright						Month Januar	р У 1	y Yea 1, 2008	N/
Exam		4a. Facility Name (If not institution,				4b. City, Town, o	r Location of	of Death		-	. County of De	
		Larkin Chase	Nursing			Bowie						Georges
Funera	1	, , , , , , , , , , , , , , , , , , , ,	6. Sex 1 ☐ M <b>2/CX</b> F	7. Age (In yrs.		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt 04-20-1	h 10 5981)		Birthplace (State or Foreign Country)
Directo	r	221-16-3022		79	Yrs.				74-20-1	720	Ma	ryland
and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	eation						10d. Inside City Limits
Aaryli F sho ed at	٥	MD	George'	Unne	r Marl	boro						1-√2 Yes 2 □ No
the N 28a- notifi	Tect	10e. Street and Number	George	ъ орре		10f. Zip Code				10g. Cit	tizen of What	Country?
with 3a or 1 be	Ö	13107 Keverton	Drive			2077	4			1	Initad	States
2 should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland nand Mental Hygiene.  Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was De	cedent Ever in U	S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Ori	igin? (Spe	cify Yes or No		14. Race - A	merican Indian,
or iter	큔	1 ☐ Never Married 2 ☐ Marrie	Armed F	Forces? 2 <b>2</b> No					Hican, etc.)		Black, W	hite, etc. Black
al", o	ğ	3 ☐ Widowed 4 X Divorced	If Yes, C Year or	Dates:		1⊡Yes 2√√2No	Specify:				Specify:	
72 ho	Completed	15. Decedent's	s Education	y))	16a. Dece	dent's Usual Occup kind of work done	ation during mos	st of workii	ng	16b. K	(ind of Busine	ss/Industry
thin ithin is Med	ğ	Elementary/Secondary (0-12)	T	(1-4or 5+)	life.	DO NOT use retire	d)			Pr	ivate	
ed wi	ြင့်	12	]		Cato	<u> </u>						
be file tal H d oth	Be	17. Father's Name (First, Middle, L					18. Mothe		(First, Middle, Simms	Maidei	n Surname)	
Men Men arke	은	Andrew Stephan	Crawfor	- u	1							
2 sh and Is m		19a. Informant's Name/Relationsh Linda C. Crudup		er	19b. Maili	ng Address <i>(Street</i> 7 <b>Kevert</b> o	n Dri	er or Rura Lve U	pper Ma	er, City a <b>rl</b> b	or Town, State oro Pi	ke 20774
and land tealth im 27			Баабия			osition (Name of	:		ate			or Town, State
paritimical ey, man yitania 2 12 13 2000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from	m State	cemetery, cre	matory or other pla	ce)	L/17/				
t. Pa tmer tant:		4 □ Donation 5 □ Other (Sp		ĸe:	surrec							aryland
Department of the popular in the pop	ביי ביי	21. Signature of Funeral Service L	icentee	a alan	2	2 Name and Addre Alexander 5538 Mar	Sign	BPEA	/Forest	tvil	le. Md	. 20747
		220 Part War ton disease 1	Complications a	t caused the deat	0)						<b>,</b>	Approximate
		23a. Part1. Enter the disease, of shock, or heart failure. List of	only one cause or	each line.	n. Do not en	ter the mode of dyr	ng, such as	o di dido o	i respiratory a	11001,		Interval Between Onset and Death
Physiciai /Medica	_	Immediate Cause (Final disease or condition resulting in death)		sis								
Examine				o (or as a conseq								
	i i	Sequentially list conditions,		cral Dec		Ulcer						-
rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,								
execu n and al-tra	Xai	resulting in death) Last	c Due t	o (or as a conseq	uence of):							
cate be executed physician and the burial-transit	dical F		d									
fficate g phy s the	edic											
The law requires that the death certification is the has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregn		Te				d	23d. Date of	delivery
death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre	e birth 2□Feta egnant at time of c		⊒Ectopic pregnand ⊒ Other <i>(specify)</i> _	:y				Month	Day Year
oy the	hys	9 Unknown	9□Unl	known								
s tha	by P	Part II. Other significant condition	_		ulting in the u	inderlying cause gi	ven in Part	1.	23e. Did t	obacco	use contribut	e to the cause of death?
v requires to been signer should be o	be d		Anemi	a					1 🗆	Yes 2	2 ₩ No 3 □	Probably 4 Unknown
aw re s bee	Completed								24a. Was		24b. Were	autopsy findings available to completion of cause of
The late has age 2	E								auto perfo 1□ Yes	psy ormed? 2⊠N	deati	h?
an: an: tiffica for, p	0	25. Was case referred to medical					26. Place	e of Death	(Check only o		9 , 3	
yslci is cer	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 [	☐Inpatient 2☐	ER/Outpatie	nt 3 DOA	her: 4X N	ursing Ho	me 5□Resi	dence	6 □Other (S	Specify)
g Ph gerthi		27. Manner of Death	/4.4	te of Injury onth, Day Year)	28b. Time o	of 28c. Inju	iry at		28d. Describe	how inj	ry occurred	
ath. r: Afte	atio	1 X Natural 5 Pending 2 Accident investig	ation	onin, bay Toai,	,,		Yes 2	]No				
Atte er deer recto	ific	3 Suicide 6 Could n 4 Homicide determin	ot be ned 28e. Pla bui	ice of injury - At h	ome, farm, st	reet, factory, office			28f. Location ( City or To	Street a	ind Number of te)	r Rural Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:			g. , , , ,								
lospl hour uner						th occurred at the t						r as stated. due to the cause(s)
the F tin 24 the F	ledical	one) f D/		anner stated.								
To To Con	Σ	29b. Signature and title of certifier	0/1/1	( )/		29c. Licen	se number	1		29d. D	are signed (M	lonth, Day, Year)
~ /			FMIL	N		Do	1500	7/		1//	4108	
y		30. Name and address of person v					_		Co	1le	ge Parl	k, Maryland
		Dr.Lkechi Fred	Okwara,	MD.6201	Green	belt Road	i, Sui	te Ü	-15,			20740
* * *	State	31. Date filed (Month, Day, Year)	32	. Registrar's Sig								

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed

**JAN <del>2-3</del>** 2008

James P. Jarboe, M.D.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

\$4035 Three Notch Road Hollywood, MD 20636

JAN 2 4 2008

use of death (Item 23a) (Type, Print)

22. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month 7:30 A<sub>M</sub> 14, January 2008 Mildred Elizabeth Wince /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's 8. Date of Birth (Month, Day, Y June 13, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Days Months Hours 1 □ M 2 🖺 F 81 214-58-1433 1926 Maryland Director Usual Residence of Decedent 10c. City, Town or Location with the Maryland 10b. County 10d, Inside City Limits 10a. State rai", or items 23a or 28a-f show Examiner must be notified at St. Mary's Piney Point 1 ☐ Yes 2X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20674 USA 45336 St. George's Avenue Funeral permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must once. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Katherine Adams Frank Joseph Eberle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 295 Piney Point, MD 20674 Warren Louis Wince / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State January 18, St. George Cemetery Valley Lee, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 22. Name and Address of Facility Signature of Funeral Service Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) /Medical Due to (or as a consequence) of) **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f Division or Vital Records, P.O. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2₩No Certification: To 4 Nursing Home 5 🗌 Residence 6 ☐Other (Specify) after death.

I Director: After this of in by the funeral d 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2∏No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide within 24 hours a To the Funeral I 29a, Certifier l 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier moy 30. Name and address of person who completed, use of death (Item 23a) (Type, Print) James P. Jarboe, M.D. Ho 1ywood, MD 20636 24035 Three Notch Road 31. Date filed (Month, Day, Year) State Registrar JAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Marguerite Jean Wardlow 11:36 PM /Medical JANUAL 4 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖺 F 220-16-5006 Director November 13,1924 District of Columbia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits show ns 23a or 28a-f show must be notified at 1 ☐ Yes 2X No Directo Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4076 Waterview Drive 21037 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ural", or item permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Itel any finury or other traumatic event, the Medical Examiner any finury or other traumatic event, the Medical Examiner. Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify White Specify: 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adrian Posey Gardiner, Sr. Marguerite Geraldine Gardiner ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Wilson / Niece 108 Acorn Street Marshfield, MA 02050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State January 26 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Ignatius Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Port Tobacco, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 20 P.A. Jardenes Leonardtown, MD 20650 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Clostridium disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) as the bunal-trans Exami and Due to (or as a consequence of) P.O. Box 68760. physician death certificate be Physician/Medical attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy fo in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐ Yes 2 No the detached 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4€Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an page 2 autopsy perform 2 No 1□ Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after ueau..

To the Funeral Director: After th 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

To the

State

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (MortiANI), 2ea 2008

Registrar

DHMH 17 Rev 1/2001

Pa-kway,

29c. License number

D56658

Armayelis.

29d. Date signed (Month, Day, Year)

22

2008

JANUARY

and manner stated.

200 medical

Registrar's Signature

M.D.

AAME

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene

2008 02409

		1- For State Registrar Certificate of D	eath	Reg. No.	1000 0140
Physici	an/	Decedent's Name (First, Middle,Last)		2. Date of Death  Month Day	3. Time of Death
ledical Exami	ner	Kelly Marie Williams		January 16, 2008	1613 Hrs
			City, Town, or Location of Death California		ounty of Death Mary's
Formul					
Funeral Director		267-17-7765 1 M 2 X F 44 Yrs.	If Under 1 Year If Under 24Hrs Months Days Hours Min	_	YYYYY) 9. Birthplace (State or Foreign North Country) Carolina
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	· -		10d. Inside City Limits
<b>*</b>			m 1		1 Yes 2 No
Aaryland 28a-f show	턍	MD St. Mary's Lexington  10e. Street and Number	Park  Of. Zip Code	10g. Citizen	of What Country?
the Ma	Director	47960 Janet Lane	20653	U. S	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once	Funeral		Decedent of Hispanic Origin? ( S specify Cuban, Mexican, Puerto		. Race - American Indian, Black, White, etc.
after c	by F		es 2 X No specify:	Sp	ecify: White
hours after 'natural'', Examiner			Usual Occupation (Give kind of of working life, DO NOT use ret		of Business/Industry
6 72 h an "n ical E	lete	Elementary/Secondary (0-12) College (1-4 or 5+)		·	
within jene.	Completed		e, R.N.		alth Care
21215-0036 Juld be filed within 7. Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)  Albert Gene Hentz		e (First, Middle, Maiden Su	,
212 ald be Menta mark	o Be		ddress (Street and Number or	Alicita Bonl	
MD d 2 show the and is a 27 is numatic			,		ood, N.J. 08108
e, N I and Health item		20a. Method of Disposition 20b. Place of Dispositio	n (Name of cemetery,		ation - City or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		1 Burial 2 X remation 3 Removal from State crematory or other Brinsfield-		.20-2008 Char	lotte Hall, MD
Iftin nit. P artme ortan ry or		21 Signature of Funeral Service Licensee	o and Address of Eacility		
Dep Dep Dep Dep Dep Dep Dep Dep Dep Dep	, u	Kyle Simons Lic.#1206 229	955 Hollywood R	rinsfield Fu	neral Home, P.A.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the			or heart Approximate Interval
Medical kaminer	9	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Cardiac Arrhythmia  Due to (or as a consequence of):			Between Onset and Death
		b			
	je	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	aminer	cause. Enter Underlying Cause (Disease or injury that imitated purpts resulting in death.) Lest			
uted d ansit	ш	events resulting in death) Last Due to (or as a consequence or):			
760, frate be executed physician and the buriat - transit	Medical	X UNPENDED AMENDED 23a,Ft.II,27 per ME	2 g878 4/28/08 amh		
760, ficate be g physici	Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. E	Date of delivery
687 certific ding	/sician/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal 4 Pregnant at time of death		ancy Mo	onth Day Year
Box 68' e death certification the attending ed for use as	ysic	1 Yes 2 No 9 V Unknown g Unknown	(Specify)		
that the detached	Phy	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did tobacco use	contribute to the cause of death?
, P.O ires that the signed by	Completed by	Chronic Alcoholism		1 Yes 2 🗸 N	lo 3 Probably 4 Unknown
Vital Records, sistem of the law require this certificate has been significate, page 2 should be	ete			24a. Was an	24b. Were autopsy findings available
e law e has	ם	-		autopsy performed?	prior to completion of cause of death?
tal Rection: The lection of the lector, page		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2 No	1 Yes 2 No
Vita ysician his cer directo	o Be	examiner?	Other		e 6 🗸 Other: Scene
n of \limits Phy. After th	$\vdash$	27. Manner of Death 28a. Date of Injury 28b. Time of Injury		28d. Describe how injury	
OD (trinding sath.	ᇋ	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No		
Division tal or Attendii rs after death. al Director: A	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, f	factory, office building, etc.		Number or Rural Route Number, City
Divis pital or At ours after d ceral Direct	Certification:	4 Homicide determined (Specify)		or Town, State)	
Hosp 24 ho Fune rely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred			
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certificate but after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	, in my opinion, death occurred	at the time, date and place	, and due to the cause(s)
F > F 0	ž	29b. Signeture and title of certifier	29c. License number	29d. Dai	te signed (Month, Day, Year)
		(Learberry)	O.C.M.E.	Janua	ry 17, 2008
		30. Name and address of person who completed cause of death (Item 23a)			
		1127	treet, Baltimore, MD 212	201	
St Regist	ate	31. Date filed (Month, Day, Year) 3. 2008 32. Resistrar's Signature	100		

ORIGINAL

			For State Registrar		State of	Marylan		artmen tificate			ınd Me	_	giene Reg. No.	800	02410
			1. Decedent's Name	(First, Middle,	Last)	_					2	2. Date of De		Vana	3. Time of Death
4	Physici /Medio		Carri	e River	s Wilson						i	Januar	y 13,	2008	3:35 P. M
	Examir		4a. Facility Name (If	not institution,	give street and numb	oer)		4b. City,	Town, or	Location o	f Death			ounty of Death	1
Y			Forestvil	le Nurs	ing & Reh	ab. Ce	nter	Fo	rest	ville				nce Geo	
	Funeral		5. Social Security Nu				last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. 8 Min.	3. Date of Bir (Month, Da )9/19/	th ly, Year)	9. Birth	place (State or Foreign intry)
	Director		578-22-1			100	Yrs.				C	9/19/	1907	Leas	burg, N.C.
	and		Usuat Residence of 10a. State	10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Mary	ò	Md.	Montg	omery		Silver	Spri	ng						1 ☑Yes 2 ☐ No
	288 288	Je C	10e. Street and Num	nber				10f. Zip	Code				10g. Citize	n of What Cou	untry?
	3a or	ā	10000 Br	unswick	Avenue ;	# 214		20	910				U.	S.A.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Dependence of Health and Mental Hygiene. Deportment of Health and Mental Hygiene. The proportment of them 27 is marked other then "naturel", or iteme 23a or 28a-f show eny injury or other traumatic event. I've Medical Exam and must be notified at once.	by Funeral Director	11. Maritat Status 1 Never Marrie 3 Never Marrie		12. Was Deceded Armed Force d 1 Tyes 2 tf Yes, Give Year or Date	es? <b>∑</b> No	'	Was Deced f Yes, spec l ☐ Yes		spanic Oric n, Mexican Specify:	gin? (Spec , Puerto Ri	fy Yes or No can, etc.)		Race - Amer Black, White pecify: B1	, etc.
2-0	72 ho	ted	(Speci	15. Decedent's	Education grade completed)		16a. Deced (Give life.	ient's Usua	I Occupa	tion	of working	,	16b. Kind	of Business/Ir	ndustry
21	men r	npie	Elementary/Secon		College (1-4	or 5+)						,			
2	ygien yerth	Completed	7th		L		Nur	se's	Assi					spital	
P	d la d	To Be	17. Father's Name (									First, Middle stelle			
yla	ould Men varke	은			Richmond									-	
, Maryland	end 2 sh salth and n 27 te m		19a. Informant's Na Emily K.				1205	42nd	St.		,Wash	ingto	n,D.C	own, State, Zi 20020	
Baltimore,	of Hi		20a. Method of Disp		3 <b>X</b> Removal from St.	1 6	Place of Dispo cometery, crer	sition (Nan natory or o	ne of ther place	9)	Da	te	20c. Loca	ition - City or T	Town, State
Ĕ	Pag ment ant: ury		4 □ Donation			High								ch, N.C.	
3alt	epert epert nport ny in		21. Signature of Fur		censee		22	. Name an	H.S.	Washi	ngtor	a & So	ns Co	.,Inc.	
	40 F 9 0			My 1	V. SAR	u	4	925 B	urro	ughs	Ave.	N.E.,	Washi:	ngton,I	o.C.20019
-	Physician /Medical Examiner	er	shock, or hear tmmediate Cause (f disease or condition resulting in death)  Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or i	rt failure. List or Final n	Due to (or	th line.	IMER uence of):	5 - 3		45E				SE .	Approximate Interval Between Onset and Death
	eath certificate be executed attending physicien end for use as the burial-transit	Aedicai Examiner	resulting in death) L		cDue to (or	as a conseq	uence of):								
P.O. Box	The law requires that the death certifica lie has been signed by the attending ph page 2 should be detached for use as the	by Physician/Med	tF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 ₱ 9 □ Unknown	months?		h 2 ∏Feta ntattime of d	death 3	]Ectopic pr ] Other (sp					23	d. Date of deliv Month	very Day Year
rds, P	luires that the dei n signed by the a ild be detached fi		Part II. Other signifi	cant condition	s contributing to dea	th but not res	ulting in the u	nderlying c	ause give	n in Part I.			obacco use Yes 2 🎘		the cause of death?
I Records,	The law requir ate has been si page 2 should	Completed										24a. Was auto perfo 1 🗆 Yes	psy ormed?	prior to co death?	lopsy findings available ompletion of cause of
/ita	cien ertific	Be	25. Was case referre	ed to medical	Han-bet				10:		of Death /	Check only	one)		
of Vital	Physicien: rthis certifica ral director, p	ပ္	1 ☐ Yes 2 <b>2</b> 1		The same of the sa		ER/Outpatier			4 (30) 140				Other (Spec	afy)
n c	ing F	ö	27. Manner of Death  1 Natural	5 Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		8c. Injury Work		1	d. Describe	how injury	occurred	
sio	Attending in death. ector: After by the funer	cati	2 Accident 3 Suicide	investiga	t he			М		′es 2 🗆 t					
5	ital or At rs after d el Direct led in by	Certification;	4 Homicide	determin	ad 286. Place of	f Injury - At he g, etc. <i>(Specif</i>	ome, farm, str	eet, factory	r, office		28	If. Location ( City or To		Number or Rui	ral Route Number,
	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	29a Certifier (Check only one)	1 Contilying 2 Medical Ex	Physician: To the bas aminer: On the bas and manne	is of examina	wledge, death	vestigation,	at the tim in my op	a, date an inion, deat	d place; an	d dua to tha I at the time,	date and p	lace, and due	clated. to the cause(s)
	To t	Σ	29b. Signature and	fitle of certifier				290	License					signed (Month	
	0		<b>&gt;</b> //	y VV	~~~ )				D :	5152	0		01-1	4-20	10 B
	ac.				ho completed cause M.D. 7420				rest	ville	,Mary	land	2074	7	
	Sta	te	31. Date filed (Monti	h, Day, Year)	32. Reg	gistrar's Signa	iture	,							
DHA	Registr	ar	JAN 15	2008	bean ?	4 6	only								
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ORIGINAL

			1 - State Registrar		,	Certificate of	Death	,	Reg. No. 2	900	0241
	Discrete:	事	1. Decedent's Name (First, Midd	le, Last)				2. Date of De		Year	3. Time of Death
*	Physici /Medio		Dean	Earl Yolton				January	13 20	008	0006 A M
	Examir		4a. Facility Name (If not institution	n, give street and number;			or Location of Dea	th		ty of Death	
	<u> </u>		Union Hospita			E1kton			Cec		
	Funeral Director		5. Social Security Number  164-46-7406  Usual Residence of Decedent	1 X M 2 □ E	ge (In yrs. last bir 50	thday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs Hours Min		rth ay, Year) , 1957	Cou	place (State or Foreigi ntry) nsylvania
	and w		10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
	Mary f she	ō	Maryland Ced	·i1	Nor	th East					1 ∐Yes 2 🎇 No
	28a-	Director	10e. Street and Number	,11	1101	10f. Zip Code			10g. Citizen of	What Cou	ntry?
	3a or	0	189 Irishtown	Road		21901			Unite	ed Sta	ates
	ms 2	Funeral	11. Marital Status	12. Was Decedent		13. Was Decedent of I		Specify Yes or No	o- 14. Ra	ace - Americ	can Indian,
Maryland 21215-0036	d 2 should be filed within 72 hours after death with the Maryland It and Mental Hyglene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Mai 3 ☐ Widowed 4 💥 Divorce	If Yes, Give 21		1 ☐ Yes 2 🏋 No		no Hican, etc.)	Spec.	ack, White, ify: Wh:	ite
2-0	72 hc natui lical	Completed	15. Deceder	nt's Education est grade completed)	16a.	Decedent's Usual Occu	pation	orkina	16b. Kind of I	Business/In	idustry
21	within ene. than "	ng n	Elementary/Secondary (0-12)	College (1-4or		(Give kind of work done life. DO NOT use retire		Sining			
21	filed w Hygier other th		12			Plumbing Es					Engineer
<u>n</u>	2 should be filed valued was and Mental Hygie Is marked other traumatic event, th	Be	17. Father's Name (First, Middle					me (First, Middle		me)	
3	should be f and Mental I s marked of umatic eve	2	Clarence Earl  19a. Informant's Name/Relation		401			s W. Tal		0	
Ma	d 2 st					Mailing Address (Street					o Code)
			Phyllis Talle 20a. Method of Disposition	y/Mother	20b. Place of	Reed Stree	t, Chadd	s Ford,	PA 1931 20c. Location		own State
٥	ages nt of : If It		1 XBurial 2 ☐ Cremation		·	Disposition (Name of ry, crematory or other pla	Joann	uary 19,		•	
Baltimore,	it. P.		4 □ Donation 5 □ Other (and 21. Signature of Funeral Service	· · · · · · · · · · · · · · · · · · ·	Elam	Cemetery	2008	3	Glen M	ills,	_PA
Ba	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once,		21. Signature of Fallorial School	0 H. A		22. Name and Addre Hicks Home 103 W. Sto	for Fun	erals, P	A. MD 3	1001	
	A - 50		23a. Part1. Enter the disease, of	or complications that cause	d the death. Do					.1921_	Approximate Interval Between
	Physician /Medical Examiner		shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	_a Myo	ine. CWZIA s a consequence	I Interc	tion				Onset and Death
	7. =	ner	Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of)·					
1	icate be executed physician and s the burial-transit	Examiner	that initiated events	с							
68760,	e exe		resulting in death) Last	Due to (or as	a consequence	of):					
876	ate b hysic the bi	Medical		d							
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e pf pregnancy 2  Fetal death at time of death	3 □Ectopic pregnanc 5 □ Other (specify) _	ey			ate of deliv	very Day Year
Δ.	that the post of t		Part II. Other significant condit	ions contributing to death	out not resulting in	n the underlying cause gi	ven in Part I.	23e. Did 1	tobacco use co	ntribute to	the cause of death?
sp.	uires sign ld be	d b	Hyppetente	Qu				1 🗆	Yes 2□ No	3 ☐ Pro	bably 4 Unknown
or Vital Records,	w requir been si should b	Completed by	1110					24a. Was	an 24h	. Were aut	opsy findings available
Re	: The law cate has I	E D						auto	psy ormed?	prior to co death?	impletion of cause of
a			25. Was case referred to medical	al			26 Place of De	1  Yes eath (Check only o	2, No	1 🗆 Yes	2 No
>	Physician: r this certifica ral director, I	o Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ER/Ou	tpatient 3 DOA Ot	her:	Home 5 ☐ Resi		thar (Space	i6.)
ō	g Phy er thi	n: To	27. Manner of Death	28a. Date of Inj	ury 28b.	Time of 28c. Inju			how injury occu	<del></del>	9/
<u>o</u>	ath. r; Aft	atio	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (Month, Da igation	ay rear)		Yes 2 No				
Division	al or Atte after des i Directo d in by th	Certification:	3 Suicide 6 Could 4 Homicide determ	not be nined 28e. Place of in building, e	jury - At home, fa tc. <i>(Specify)</i>	rm, street, factory, office		28f. Location ( City or To	Street and Nun wn, State)	nber or Run	ral Route Number,
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	edical (	29a. Certifier (Check only one)  12 Certifyi 2 Medica	ng Physician: To the best i Examiner: On the basis and manner s	of examination ar	e, death occurred at the t d/or investigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time	cause(s) and r , date and place	nanner as s	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certific	er _//		29c. Licen	se number		29d. Date sign	ed (Month,	Day, Year)
			* Harola	To Classic	M)	20	05990	3	1/15/	801	
-			30. Name and address of persor	who completed cause of	death (item 23a)	(Type, Print)					
	15		Pamela LeClaire	, M.D., 104	E. Ceci	l Ave., Nort	th East.	MD 2190	1		

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) JAN 1 6 2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Yom 2008 Mo Hong lan. ろ、200つ 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death RehabaNursinaCtr Wicomico lisbury R 15 bure If Under 1 Year | If Under 24 Hrs/ Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 1 X M 2 □ F South Korea May 9,1923 212-37-7567 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Delmar MD Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21875 South Korea 916 E. State Street Apt. 24 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify Specify: Asian 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Farm 11 Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Yom 0wak Soon Moon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29557 Stillwood Drive Delmar, MD 21875 Kyung Yom- Son 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Wicomico Memorial PK 1/15/08 Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home Salisbury, MD 21804 705 E Main Street Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ears 110 11 Due to (or as a consequence of): ear c an Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year ne cause of death? 4 ☐Unknown psy findings available 2 □ No

**Physician** /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, physician attending philosophia at the

Physician

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner.

Baltimore, Maryland 212-0036

Hong

Director

Funeral

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Completed

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death with the Maryland

Certification:

certificate

Examine

Physician/Medical

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Completed

Be 2

Medical

29a, Certifier

29b. Signature and title of certifier

Illiam

31. Date filed (Month, Day, Year)

H

1  Yes 2  No 9  Unknown	9 Unknown			
Part II. Other significant conditions o	contributing to death but not resulting in the underlying co	ause given in Part I.	23e. Did tobacco us 1 ☐ Yes 2 ☐	se contribute to the cause of death → No 3 Probably 4 Unkr
			24a. Was an autopsy performed? 1□ Yes 2⊡ No	24b. Were autopsy findings avail prior to completion of cause death? 1 □ Yes 2 □ No
25. Was case referred to medical		26. Place of Deatl	h (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DC	OA Other: 4 Nursing Ho	me 5 Residence 6	Cother (Specify)
27. Manner of Death 1 ☑-Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	/ occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory building, etc. (Specify)	y, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,

and manner stated

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

within 24 hours after death To the Funeral Director:

State Registrar 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 29, 2008 **Physician** 8:55 aM Archer Doris Jean /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 524 East 35th. Street Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 71 vrs Funeral Days Months Hours 9/19/1936 212-34-7601 1 M 20X PΑ Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at Baltimore 1 XYes 2 No MD Director 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 3502 Old York Road 21218 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? and 2 should be filed within 72 hours after or ealth and Mental Hygiene. m 27 is marked other than "natural", or Iter 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Shipping Office Manager 12 17. Father's Name (First, Middle, Last)
Ralph R. Gate 18. Mother's Name (First, Middle, Maiden Surname)
Frances L. Gutshall Be and Mental I Ra1ph Gates 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 279 Tansdowne Dr. Noblesville, IN 46060 19a, Informant's Name/Relationship (Type. Print) Rosalie C. Robinson / Sister 279 Lansdowne Dr. Noblesville, permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buria! 2 XCremation 3 ☐ Removal from State 1/29/2008 Baltimore, MD Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MI Trensee Victor P. Doda East Fort Avenue, Baltimore, MD 21230 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final Month **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.0. 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 No 1∐ Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 28c. Injury at Work? Certification: or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 29a. Certifier া 🕳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) Osle- Brive, Suite GO4 Town 7501 0900 coIL

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, JAN 3

Year)

32. Registrar's Signature

		h-	Tor S≀ate Registrar	State of Ma	ırylan	_			lealth a Death			gien Reg. N	ZHIB	0241	4
	Physici		1. Decedent's Name (First, Middle, La	st)		+	40	m	00		2. Date of De	ath	ay. 29, Year 200	3. Time of Death	М
	/Medio Examir		4a. Facility Name (If not institution, giv	HOST	sit	al	73	THI	Location of	e		Ва	c. County of Death	City	
	Funeral Director		210-12-0/53	ox 7. Age □M 2\QF 8		last birthday) Yrs.	Month	Days	If Under Hours	Min.	8. Date of Bir (Month, Da Apr. 2	y, Year		pplace (State or Foreig Intry) 7 land	Эn
	Maryland -f ehow ind at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne Aru	ndel		y, Town or Lo				`				10d. fnside City Limit	
	ith the	Director	10e. Street and Number				10f. Z	ip Code				10g. C	itizen of What Cou	intry?	_
	s 23a	rail	350 Cresswell Rd.	T		2 1.0		21225					ited Stat		_
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if tiem 27 is marked other than "patural" or items 23a or 28a-f ehow eny injury or other traumatic event, the Madical Examinar must be notified a once.	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1  Yes 2 XN ff Yes, Give Year or Dates:			_		Specify:		cify Yes or No Rican, etc.)	)-	14. Race - Amer Black, White Specify: Whi	e, etc.	
Baltimore, Maryland 21215-0036	hin 72 ho B. Rn "natur Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		+)	16a. Dece (Give life.	kind of v		durina mos	t of workin	g	16b. 1	Kind of Business/	ndustry	
2	ygien ygien t, the	Соп	12			Homem	aker						1 Home		
and	d be fi	To Be	17. Father's Name (First, Middle, Last, Charles Sterling								<i>(First, Middle,</i> ie Ster				
ary	shoul and Mark smark	Ĕ	19a. fnformant's Name/Relationship (				-		and Numbe	er or Rurai	Route Numb	er, City	or Town, State, Z		
<u>ک</u> ش	and and a lealth m 27 in the tre		Eileen Phillips	/ Daughter	20h B								, Maryla		
imor	Pages : ment of H ant: if ite ury or ot		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specif		0	Place of Dispo emetery, crei DWNSV1.	matory or	other plac	t. Ce	Feb.	1, 2008		Location - City or 1 wnsville	, Maryland	ŀ
Balt	Departition Depart		21. Signature of Funeral Service Liber	ns <del>ee</del>		K 4	irkle 21 C	nd Addres y-Ru ain	ddick Hwy.,	Fune S.E.	eral Ho	ome, 1 Bu	P.A. rnie, MD	21061	
	Physician		23a. Part T. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin	Θ.									Approximate finterval Between Onset and Death	
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		Completed by											prior to o	opsy findings available ompletion of cause of	le
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ō	ding Phys h. After this funeral di	n: To	1 ☐ Yes 2 ☒ No  27. Manner of Death	28a. Date of Injur	/	ER/Outpatier 28b. Time of		OA Dury 28c. Injury Work	4 LI NU		e 5 Residente 18d. Describe I		6 ☐Other (Specury occurred	ify)	
ion	Attending Physician: r death. sctor: After this certific by the funeral director.	atlo	1 Natural 5 Pending 2 Accident Investigation		Year)	Injury	м		<br Yes 2 □ l	No					
DIVIS	- 2	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	building, etc	. (Specify	r)					City or Tox	wn, Stai	,		
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best on niner: On the basis of and manner state	examina	wtedge, death tion and/or in	h occurre vestigatio	d at the tim n, in my of	ne, date an pinion, dea	d place, a th occurre	nd due to the d at the time,	cause(: date ar	s) and manner as nd place, and due	stated. to the cause(s)	
	To the within 2 To the complei	Me	29b. Signature and title of certifier	1		<u> </u>	29	c. License				29d. D	ate signed (Month	, Day, Year)	
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			30. Name and address of person who CANUS Dr 21650					C 60	1-41	was	V C.	ENI	BUDALC	mb 20061	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	そ(O r's Signa	ture	06	>r (14	ANI	7 30	1,60	L/V	MICHAIG	100 200	
- 2	Registr	ar	JAN 3 1 201	IX M.	11.		A 17"								

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Eleanor Arent 8:40 AM M January 18, 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Jones Acre Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 15, 1 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🔀 F Yrs 065-20-9392 83 Director 1924 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Item 27 is marked other then "neturel; or Iteme 23s or 28s-f show other traumatic event, the Mudical Examinar must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1 Belleview Drive 21146 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) 12 mechanic permit. Pages 1 and 2 should be filled.
Department of Health and Mental Herimportant: if item 27 is meny highly or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julius Scinecki Rose Kuzio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Arent/son 1 Belleview Drive Severna Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. W. 22. Name and Address of Facility State Anatomy Board Wade. 655 W. Baltimore Street Baltimore, MD Approximate Interval Between Inset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) STro **Physician** ear /Medical Due to (or as a co sequence of) Examiner 1 u Met Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 99 icate has been sig , page 2 should b 1 Yes 2 1 4 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed 2006 1 Yes 2 1 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Certification: To 1 Yes 2 ER/Outpatient 3 DOA JSISHE 28a. Date of Injury (Month, Day Year) of Death 27. Manne 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funerel Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 02009

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

3

Madison Park

pleted cause of death (Item 23a) (Type, Print)

y (M) | Y||
32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene UU8 Amend # 12,17-18, perFH, g876, 2/5/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month **Physician** KENNETH T. BUCKLEY JAN. 29 2008 8:20AM /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner LORÍEN NURSING & REHABILITATION CENTER COLUMBIA HOWARD if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 12/06/1928 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex 12 M 2 □ F **Funeral** Davs Months Hours WASHINGTON, DC 79 579-32-5097 Director Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours eftar death with the Maryland nant of Health end Mantel Hygiana. Int: if Itam 27 is marked other than "natural", or items 23s or 28s-f show 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location event, the Medical Examiner must be notified at MD FREDERICK 1 to Yes 2 □ No MT. AIRY Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 5125 NIAGARA DRIVE 21771 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes <del>2∑ Ne</del> If Yes, Give Year or Dates: 1945–48 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Merital Status 1 ☐ Never Married 2 TM Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) WASHINGTON, Elementary/Secondary (0-12) College (1-4or 5+) FIRE DEPARTMENT FIRE FIGHTER 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) DESALLES BUCKLEY ANN BRYAWI, Annie Bryant 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Depertment of Health e important: if itam 27 is any injury or other traconce. DORIS BUCKLEY / WIFE 5125 NIAGARA DRIVE, MT. AIRY, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State FT. LINCOLN CEMETERY 02/01/08 BRENTWOOD, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility HOWELL FUNERAL HOME 21. Signature Anneral Service Licenses 10220 GUILFORD ROAD, JESSUP, MD 20794 , or complications that caused the death. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Physician Imme - e Cause (Final disease or condition resulting in death) /Medical hours Examiner Examiner The law requires that the death certificate be executed Due to (si as a co isequence si) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tyes Hospital or Attanding Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after deeth.

To the Funeral Director: After this completely filled in by the funeral 28a. Date of Injury (Month, Dey Year) 27. Menper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pendina investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier \$ 29d. Date signed (Month, Day, Yeer) 29c. License numbe 29b. Signature and title of certifie IVA 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 5/00M Lorien Columbia RCCa

**DHMH 16 Rev 6/95** 

Registrar

31. Dete filed (Month, Day, Year)

JAN 3

32. Registrar's Signature

				ype or Print in E State of Marylan						Legible.	
				Per FH g876 2				u wentai ny	/gierie Reg. No.:	2000	021.17
D			Decedent's Name (First, Middle, Last)		-, 0. pu	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	204117	2. Date of D	eath	<u> </u>	3. Time of Death
	Physicia /Medic		HENRY	BAdder	25			Month	30	2008	5 1155AM
	Examin		4a. Facility Name (If not institution, give s.	1		4b. City, Town, o		Peath	4c.	County of Dea	
			5. Social Security Number 6. Sex	Varleway P.Age (In yrs.	last hirthday)	Paulc If Under 1 Year		Hrs. 8. Date of B	rth	-	thplace (State or Foreign
	Funeral Director		, , , , , , , , , , , , , , , , , , , ,	M 2□F 9(		Months Days		03/14	71917		oryland
	f show	tor	10a. State 10b. County N/A		y, Town or Loc timore	ation					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
44	r 28a notif	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What C	ountry?
4444	23a o 23a o 1st be	al D	4606 Frankford Ave	nue		21206			U.S	.A.	
1	tems ter m	nue		<ol><li>Was Decedent Ever in U Armed Forces?</li></ol>	.S. 13. W	Vas Decedent of H Yes, specify Cub	lispanic Origin' an, Mexican, P	? (Specify Yes or N Puerto Rican, etc.)	0-	<ol> <li>Race - Ame Black, Whi</li> </ol>	
2	ir, or	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1	1	☐ Yes 2 🔀 No	Specify:			Specify: W	hite:
	z nou		15. Decedent's Educ	ation —	16a. Deced	ent's Usual Occup	pation	t alda a	16b. Kir	nd of Business	/industry
1717	should be thest within 72 hours after death with the Maryland that Mental Hygiene.  In marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Completed	(Specify only highest grade	College (1-4or 5+)	life. D	kind of work done O NOT use retired Opractor	during most of d)	working	He	alth Ca	ire
	permit. rages i and 2 should be filed writin Department of Health and smarked other than Important: If Item 27 Is marked other than any Injury or other traumatic event, the M once.	To Be (	17. Father's Name ( <i>First, Middle, Last</i> )  James Badders					Name <i>(First, Middle</i> Name (First, Middle	e, Maiden	Surname)	
מוץ	and N		19a. Informant's Name/Relationship (Typ					or Rural Route Num			
1	and 2		Peggy Ann Badders,				rd Aven	ue, Balti			
5	rages in nent of He int: If iten iny or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, crem	sition (Name of hatory or other place Cemetery		Date /04/2008		cation - City or	Town, State Maryland
ò	artmer artmer ortant injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License			Name and Addre	i	Lecnard	I .	•	•
	Departr Departr Importa any Inji		Palepondua ?	Blair	- 1		-	, Baltimo			
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	ations that caused the deat cause on each line.					-		Approximate Interval Between Onset and Death
	hysician /Medical	Н	disease or condition resulting in death)	Due to (or as a conseq		-					2 weeks
E	xaminer		h	Dusahria	,						mmllis
7	D #44	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to ( r as a r nseq					**		
of look	and II-transit	xamine	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a conseq	mence of/:						700-5
	physician s the burial	ш		Due to (or as a conseq	dence on.						
	phys phys s the	edic	d.			-					
The law requires that the description and additional additional add	ned by the attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3 🔲	Ectopic pregnanc Other <i>(specify)</i>	у		2	3d. Date of de Month	elivery Day Year
- 4	igned b	by PI	Part II. Other significant conditions conf	-			ven in Part I.	23e. Did	tobacco u	se contribute t	o the cause of death?
	been sig	ed k	Dementa	rema	1115	Flicens		_ 1□	Yes 2€	<b>3</b> √No 3□P	robably 4 Unknown
	as be	Completed	PE					24a. Wa	s an opsy	24b. Were a	utopsy findings available completion of cause of
		Son	DUT					per 1⊟ Yes	ormed? 2₽No	death? 1 □ Yes	
a deloi	this certificate al director, pag	Be	25. Was case referred to medical examiner?	espital:		3□ DOA Oth	or:	Death (Check only			
Attending Physician	r this	<u>۽</u>	1 ☐ Yes 2 ☐ No	28a. Date of Injury	ER/Outpatient 28b. Time of	3 DOA   28c. Injut	4 Nursir	ng Home 5 ☐ Res 28d. Describe			ecify)
	th.	tion	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk? ∣Yes 2∐No		,		
2 4	within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, stre fy)	et, factory, office		28f. Location City or To	(Street and	d Number or A	tural Route Number,
) =	urs aft										
Hoe	nin 24 hours the Funeral	Medical	29a. Certifier 1	cian: To the best of my kno er: On the basis of examina and manner stated.	wiedge, death ation and/or inv	estigation, in my	me, date and p opinion, death (	occurred at the time	e cause(s) e, date and	and manner a place, and du	s stated. e to the cause(s)
To the	Vithin Complete Compl	₩	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	e signed (Mon	th, Day, Year)
			What Kly is			731	1395		11.	30/08	
	7	.	30. Name and address of person who cor	npleted cause of death (Iten	n 23a) (Type, F	Print)		,	a . 1	212.1	
	V		Wandy Kloisz	6701 N Cha	- W St	Jun 7	1202 /	owson 2	ne	21204	
	Sta Registr	te ar	30. Name and address of person who con Wendy Klots L  31. Date filed (Mooth, Day, Year) 2008	ez. Hegistrar's Signa	ature	K)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** anuari 26 Bernard Ellsworth Brooks Jr /Medical 4c. County of Death Facility Name (If not institution, give street and nun 4b. City, Town, or Location of Death Examiner Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 ☐ F Yrs. Director 216-42-2792 Maryland 05/22/1945 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits show ed at a or 28a-f shot be notified a 1XYes 2□No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a iner must b 14. Race - American Indian, 601 Brookwood Road Completed by Funeral and 2 should be filed within 72 hours after death <u> 21229</u> 12. Was Decedent Ever in U.S Armed Forces? 1964 1 X yes 2 □ No If Yes, Give Year or Dates: 1967 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Electric other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Health and Menta em 27 is marked Bernard Ellsworth Brooks Sr. 2 Lula J. Winder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other Doris H. Brooks / Wife 601 Brookwood Road, Baltimore, Maryland 21229 altimore, Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition i o = 20 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) Woodlawn Cemetery 02/01/2008 Gwynn Oak, Maryland permit. 22. Name and Address of Facility 21. Signature of Funeral Service Licens The Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause are each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) 68760 the death certificate be Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy jo in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 🗆 No Ö 9 Unknown 9 Unknown <u>م</u> 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Current 1∐ Yes 2 No Attending Physician: in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ò within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ca 24 and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)  $\langle \chi \rangle$ Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mary			of Health and No		ene 3. No. 2008	02419
	Physici		Decedent's Name (First, Middle, Last)	David W.	Beverly,	Sr.		2. Date of Death Month Jar	24, 2008 Year	3. Time of Death 9:00p
	/Medic Examin		4a. Facility Name (If not institution, give s Futur	treet and number) e CareIrvingto	n	4b. City, Tov	vn, or Location of Death Baltin		4c. County of Deat	Î⁄Α
	Funeral Director		5. Social Security Number 218-54-4634 6. Sex	7. Age (h	n yrs. last birthday) 55 Yrs.	If Under 1 Y Months D	ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day, 1	9. Birt	hplace (State or Foreign Maryland
	pu *		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
	e Maryla ia-f shov iffied at	ctor	Maryland N/A		oc. Oity, 10wil of Et	Julian	Baltimore			1 ☐ Yes 2 ☐ No
	h with th	ai Dire	10e. Street and Number 2817 Ridgewood Avenue			10f. Zip Co	21205	10	g. Citizen of What Co U.S.	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural', or items 23a or 28a-f show appringury or other traumatic avant, I'm M. died Examiner wast be notified at ance.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Eve Armed Forces? 1 Tes 2 No If Yes, Give Year or Dates:		Was Decedent If Yes, specify	of Hispanic Origin? (Si Cuban, Mexican, Puerto No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	within 72 ho ene. than "natur he M. ulcul	Be Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual O kind of work of DO NOT use r	one during most of wor.	king	6b. Kind of Business/ Auction	
and 2	ld be filed ental Hygia ked other ic avant, II	To Be Co	17. Father's Name (First, Middle, Last) Alphonzo	Beverly			18. Mother's Nan	ne (First, Middle, M Marth	aiden Sumame) a Beverly	
Mary	nd 2 shou Ith and M 27 Is mari	1	19a. Informant's Name/Relationship (Ty) Sharon Beverly	рө, Print)	19b. Maili <b>28</b>	ng Address (S. B17 Ridge	reet and Number or Ru wood Avenue Ba	ral Route Number, altimore, Mary	City or Town, State, 2 land 21215	Zip Code)
altimore,	Pages 1 ar nent of Hea nt: If item:		0c. Location - City or Town, State Lansdowne, Maryland							
Balti	permit. Departm Importa any inju		21. Signature of Fundamental Livense	Walk?	S 73 2	2. Name and A Este 1300	ddress of Facility o Brothers Fune o Eutaw Place B	ral Service, P altimore, Md 2	A. 21217	
	Pnysician /Medical		23a. Partz Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	1	eun	ter the mode o	dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Examiner	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c						
8760, 🖈	icate be executed physician and s the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of):					
P.O. Box 68	ne death certif the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of a control of the control of	Fetal death 3	⊒Ectopic pregr ⊒ Other (speci			23d. Date of de Month	ivery Day Year
	w requires that the state of th	b	Part II. Other significant conditions con	tributing to death but r	ot resulting in the u	inderlying caus	e given in Part I.		acco use contribute to	the cause of death?
Vital Records,		Completed	Renal F	dilwe		/		24a. Was an autopsy perform	ed? 24b. Were at prior to death?	utopsy findings available completion of cause of
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:			- 1	th (Check only one		
Division of \	ing Phys Atter this uneral di	tion; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	2 ☐ ER/Outpatie 28b. Time c ear) Injury		Injury at Work?  1 Yes 2 No	ome 5 Resider 28d. Describe how	nce 6 Other (Spe v injury occurred	cify)
Divisi	l or Attandi after death. Diractor: A	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, st Specify)	reet, factory, o	ffice	28f. Location (Str. City or Town,	eet and Number or Ri State)	ural Route Number,
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	To th within To th compl	Me	29b. Signature and title of certifier	1SICIA	N		cense number	29	d. Date signed (Mont	
	1		30. Name and address of person who co			9		BALT		
	Sta Registi		31. Date filed (Month, Day, Year) JAN 3 1 2008	32. Registrar's	Signature	8)	,			nn 21223

			1- For State of Maryla Registrar		nent of Hea		, ,	ene 2008	02420			
	Physici	ian	1. Decedent's Name (First, Middle, Last) PATRICIA	CRIS	110	-	. Date of Death Month	Day Year	3. Time of Death			
	/Medi Examir	cal	4a. Facility Name (If not institution, give street and number)		City, Town, or Lo		TANUARY	25 2008 4c. County of Death	(-40 I M			
				XTON	To	DWSON	2	BALTIC	MORE			
П	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yr 214-38-8425 1 M XXF 67			Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Y May 23, 1	(ear) 9. Birthp Coul 940 Mar	olace (State or Foreign otry) Vland			
	ō		Usual Residence of Decedent           10a. State         10b. County         10c. 0	City. Town or Locatio					0d. Inside City Limits			
	Maryla	to	Maryland N/A	ony, rown or Educatio		imore Cit	-y		1XXYes 2 No			
	or 288	Direc	10e. Street and Number	16	Of. Zip Code		10g	. Citizen of What Cour	ntry?			
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920	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic avant, It's Modical Examilinat must be notified at	by Funeral Director	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	If Yes		anic Origin? (Specif Mexican, Puerto Ric Specify:	an, etc.)	Black, White,				
21215-0036	in 72 ho n *natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's (Give kind life. DO N	Usual Occupation of work done during IOT use retired)	n ng most of working	16	b. Kind of Business/In	dustry			
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Maryland	2 should be filed withir and Mental Hygiene. Is marked other than raumatic avant, It s M.	Be	17. Father's Name (First, Middle, Last)  Jack Gaydosh		18.	. Mother's Name (F Margaret						
aryl	2 should be f and Mental b is markad of aumatic ava	10	19a. Informant's Name/Relationship (Type, Print)			Number or Rural R	Route Number, C	City or Town, State, Zip				
	1 and 2 Health tam 27 l		Margaret Petway (Daughter)  20a. Method of Disposition 20b	7846  Place of Disposition		re Lane		c. Maryland				
mor	Pages nent of H ant: If its ury or of		2OBurial 2 □ Cremation 3 □ Removal from State	cemetery, cremator	y or other place)			Middle Riv				
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or othar tr <u>once.</u>		21. Signature of Funeral Service Licensee					of Dundalk, Inc.				
r.			23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Pnysician /Medical		resulting in death)	G CAI	UCER				Onset and Death			
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8760,	cate be chysicia the bu	dical	d									
.O. Box 6	death certii e attending id for use a	by	by	by Physiclan/Me	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3 Ecto	pic pregn <i>a</i> ncy er (specify)			23d. Date of delive Month	ery Day Year
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Vital	Physician; Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Other	. Place of Death /C	Check only one)					
o		on: To	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 [  27. Manner of De ath 1 ☐ Thatural 5 ☐ Pending (Month, Day Year)	28b. Time of	28c. Injury at Work?		5 Residence  I. Describe how	e 6 Other (Specify injury occurred	/)			
Division	Atten	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spec	Location (Street and Number or Rural Route Number, City or Town, State)								
	lospita hours uneral	dical Ce	29a. Certifier  (Check only  29   Medical Examiner: On the best of my kr	nowledge, death occu	urred at the time, d	late and place, and	due to the caus	se(s) and manner as si	ated.			
	To tha Hos within 24 h To the Fur completely	Med	one) and marrier stated.  29b. Signature and title of eartifier		29c. License nu			. Date signed (Month,				
			) Clerk	$M \cdot D$ .	051	122	5/	ANUARY 2	7 2008			
	(2)		30. Name and address of person who completed cause of death (Ite  LEONARD RICHARDSON M.D. 15		NE TOP	0000 # 2	on P. W.	ESVILLE MD	21200			
•	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Sign		A TACC	(WAY # >	U LIFE	will mp	-1208			
	Registr	ar	JAN J 1 (000 ) 25 Mar A	S. S. S. S. S. S. S. S. S. S. S. S. S. S	3							

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Mary Elizabeth Clayton JANUARY 05:03 PM 25 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BPCT(IV) DKT (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) A 14 57 BALTIMORF BACTIMORE HOSPITAL OF 5. Social Security Number Birthplace (State or Foreign Country) 1 □ M **X**□ F 50 245-98-4700 MD Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits NA Windor Mill 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7101 Rutherford Green Circle 21244 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes ¾☐ No Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 2yrs Elementary/Secondary (0-12) Emergency Medical Tech. 12th grade Ambulance Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herman Clayton Elizabeth Clayton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7101 Rutherford Green Circle, Frances Robinson-Friend Winsor Mill 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 2/1/08 4 ☐ Donation 5 ☐ Other (Specify) Randallstown, Md 21. Signature of Funeral Service License March Address of Facility 4300 Wabash Ave, Baltimore, Md 21215 23a. Par 1. Enter to disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BRAIN PEATH HOURS disease or condition resulting in death) Due to (or as a consequence of) EXTENSIVE INTRA CRANIAL HAEMORRHAGE DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MYPERTENSION YEARS Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? BERRYANEURYSM 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown HYPER LIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ Mo 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 5 ☐ Pending investigation

/Medical Examiner The law requires that the death certificate be executed use as the burial-trai Division or Vital Records, P.O. Box 68760,

**Physician** 

s been signed by t should be detach page this certificate

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Baltimore,

Director

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Certification: To

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Physician/Medical

or Attending Physician: funeral After ours after death.

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filled in by the fu

To the Hospital within 24 hours a To the Funeral I

29b. Signature and title of certifier

31. Date filed (Month

29a. Certifier

2 Accident

3 ☐ Suicide

4 Homicide

(Check only one)

SHARMA

6 ☐ Could not be

determined

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number RES-000

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 25 08

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARUN

HOSPITAL OF BALTIMORE MD SINAI

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Allen James Carter January 26 2008 4:40 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1307 East Madison Street Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 09/21/1937 Birthplace (State or Foreign Country) Months Days Hours 1 M 2 F 70 226-42-0024 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1307 East Madison Street 21205 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stee! Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William McKinley Carter Thelma Lawson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Munson / Fiance 1307 E. Madison Street, Baltimore, Maryland 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 02/02/2008 Landsdowne, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, PA 21. Unature of Funeral Service Licenses 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC LUNG CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

requires that the death certificate be executed and burial Division or Vital Records, P.O. Box 68760, physician the as attending properties for use as page 2 s has certificate

Hospital or Attending

Examiner Physician/Medical 9 Completed Be Medical Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f st any Injury or other traumatic event, the Medical Examiner must be notified

**Physician** 

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Examiner

Baltimore, Maryland 21215-0036

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this funeral After within 24 hours after dex To the Funeral Directo completely filled in by th

				24a. Was an autopsy performed 1 Yes 2 M No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2□No			
25. Was case referred to medical examiner?			ith (Check only one)	(Check only one)				
1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	OOA Other: 4 Nursing H	ome 5 Residence 6	☐Other (Specify)			
7. Manner of Death  1		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	occurred			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, factory)	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,				
29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated	wledge, death occurre	ed at the time, date and place on, in my opinion, death occu	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)			

annah Xoarer MD

29c. License number D16619

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VERGARA - SOARES

9940 FRANKLIN GOWRE DR. BALTIMORE, MD 21236

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32 Registrar's Signature

เช-บบชบง Bary Richard Ca	irne	Please Type or Print in Black Inde	elible Ink. Ensure All Copies ment of Health and Mental Hygi			
bary Monard Oc	•	1- For State Certifi	cate of Death	2000 021	, 2	
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last)	2.	Reg. No. 3. Time of Death Month Day Year 2339 hrs		
and in		4a. Facility Name (if not institution, give street and number) Union Hospital	4b. City, Town, or Location of Death	4c. County of Death Cecil		
Funeral	-	5. Social Security Number 10 6. Sex 7. Age (In yrs. last b	oirthday)   If Under 1 Year   If Under 24Hrs.   8	B. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or	$\dashv$	
Director		<del>999 99 9999</del> X 1 M 2 F 40		04/20/1967 Foreign Country Marylar	nd	
any		Usual Residence of Decedent  10a. State	vn or Location	10d. Inside City Lin	mits	
<b>*</b> .	tor	MD Harford	Edgewood	1 Yes 2 X	No	
ith the Maryland 23a or 28a-f sho n siffed at once.	Director	10e. Street and Number 650 Longwood Ct.	10f. Zip Code 21040	10g. Citizen of What Country? United States		
th with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Specing Yes, specify Cuban, Mexican, Puerto Richard</li> </ol>			
er dea	F	1 Yes 2 No 3 Widowed 4 Divorced if Yes, Give Yeer	1 Yes 2 No specify:	White		
urs aft tural'	d by	or Dates:	a. Decedent's Usual Occupation (Give kind of work	Specify:  done 16b. Kind of Business/Industry		
72 ho n "ua al Ex	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retired			
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed by	10	Laboror	Construction		
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland tht and Mental Hygiene. n 27 is unarked other than "natural", or items 23a or 28a-f sho umatic event, the Medical Examiner must be natified at once	Be	17. Father's Name (First, Middle, Last) Gary Richard Carpenter	Evelyn	rst, Middle, Maiden Surname) Ferguson		
	ပို	19a. Informant's Name/Relationship (Type, Print)  Evelyn Lipira / Mother	19b. Mailing Address (Street and Number or Rura 650 Longwood Ct., Edge		73	
		20a. Method of Disposition  20b. Plac  20b. Plac  20cern  20cern  20cern  20cern	e of Disposition (Name of cemetery, Datory or other place)	date 20c. Location - City or Town, State		
imore Pages 1 ment of H taut: If i		4 Donation 5 Other Specify:	natory or other place) capeake Crematory 1/25,	/08 Beltsville, MD		
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		21. Signature of Funeral Service Licensee Moo 382	22. Name and Address of Facility CAFA Stephen D. Loh: 8717 Green Pastures	rmann P.A. Dr., Baltimore, MD 21286	5	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.		spiratory arrest, shock, or heart Approximate Inte Between Onset	erval	
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tox 68760, eath certificate be attending physicia for use as the buris	/Me	IF FEMALE: 23c. If yes, outcome of pregnant	Су	23d. Date of delivery		
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Box e death c the atten ed for us	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown	Uniter (Specify)			
ires that the disagned by the	à	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death  1 Yes 2 No 3 Probably 4 Unkno		
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Recol The law cate has	ЩC			performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No		
tal Recian: The certificate ector, page	ا به	25. Was case referred to medical	26.Place of Death (Check only			
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<b>-</b> ± . ^ ≥	tion: T	1 Natural 5 Pending FO(Month, Day, Year) FO		d. Describe how injury occurred ubject hanged self		
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Divis To the Hospital or A within 24 hours after To the Funeral Dire		4 Homicide (Specify) Jail/Penal 29a. Certifier 1 Certifying Physician: To the best of my knowledge, of				
To the within 2 To the Complet	Medical	one) 2 Medical Examiner: On the basis of examination and/o				
FFF	ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)		
		Mhng Geasel 112	O.C.M.E.	January 22, 2008		
2		30. Name and address of person who completed cause of death (Item 23a Melissa Brassell, MD Assistant Medical Examiner	111 Penn Street, Baltimore, MD 21	201		
St Regist	ate	31. Date filed (Month Dev. Sar) 2008 32 Sedistrar's Signature				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- Fortate Registrar Amend 10c, perFH,g875, 1/31/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day orma arnel Tanuary 0200 A M /Medical 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death University Mary land Balhmore, MD Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7 Age (In vrs. last birthday) **Funeral** Months Days Hours 215.42.2466 63 Director 10.24.1944 MD Usual Residence of Decedent the Maryland or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PA York -N/A 1 Yes 2 10 Stewartstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with trent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or; ury or other traumatic event, the Medical Examiner must be n 19129 Valley Road 17363 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman E. Smith Frances Pearl Buell ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred Carnell, Jr./ Husband 19129 Valley Road, Stewarstown, PA 17263 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory 01.29.08 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, MD 4 Donation 5 Dother (Specify) 21. Sigrature of Funeral Service Licensee 22. Name and Address of Facility Cafa/Stephen D. Lohrmann P.A. 8717 Green Pastures Drive, Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 24 hours /Medical Due to (or as a consequence of): Examiner necrotizing fasciitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month 4□Pregnant at time of death 5 Other (specify) ed by the a 9∏Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? this certificate or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient P 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) onta 26 2008

10

State Registrar

DHMH 17 Rev 1/2001

Baltimore

2120

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

\*Greene

32. Registrar's Signature

S. Montgomery

31. Date filed (Month Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Of Ivid		artment of Heal ctificate of Dea		aı Hygie Reg.	2000	02125					
25	Physici	an	1. Decedent's Name (First, Middle, Last)				ate of Death	Day Year	3. Time of Death					
1	/Media	cal	Raymond D. Cronhardt		4.0: -	J		27 2008	11:58 P <sup>M</sup>					
Þ	Examir	ier	4a. Facility Name (If not institution, give street and number) 8173 Orchard Point Road		4b. City, Town, or Locat Pasadena	tion of Death		4c. County of Death U.S.A.	n					
<u>.                                    </u>	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year   If Ur	nder 24 Hrs. 8. Da	ate of Birth	9. Birth	nplace (State or Foreign					
)Ç	Director		219-18-0952 <sup>1</sup> X <sup>M 2□ F</sup>	84 Yrs.	Months Days Hou		onth, Day, Ye		vland					
	land ow tt		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits					
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	ith the	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	untry?					
	s 23a nust k	ral	8173 Orchard Point Road		31122			S.A.	<del></del>					
	fter de r Item iner n	Funeral	11. Marital Status 12. Was Decedent E Armed Forces? 1 ☑ Never Married 2 ☐ Married 11☑ Yes 2 ☐ N.	verin U.S. 13. V	Vas Decedent of Hispanio f Yes, specify Cuban, Me	c Origin? (Specify Y xican, Puerto Rican,	es or No- , etc.)	14. Race - Amer Black, White						
036	ours a ral'; o Exam	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		l∐Yes 2 <b>⊠-N</b> o <i>Spe</i>	ecify:		Specify: Whi	ite					
5-0	"natu	etec	15. Decedent's Education (Specify only highest grade completed)	(Give	ent's Usual Occupation kind of work done during	most of working		. Kind of Business/li	,					
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or ttems 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+	Route	OO NOT use retired)		Ba	altimore S	Sun Papers					
	al Hyg other	Be C	17. Father's Name (First, Middle, Last)	<u> </u>		Nother's Name (First	, Middle, Maid	den Surname)						
Maryland	ould b Ment larked	To	Raymond N. Cronhardt			ila Davis								
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Type. Print)  Keith Cronhardt/Son		g Address (Street and Nu Dubbs Drive									
	s 1 and 2 of Health a item 27 is other tra		20a. Method of Disposition		sition (Name of natory or other place)	Date		Land 2114 Location - City or T	• •					
m 0	Page nent o int: If iry or		1 ☐ Burial 2	1 .	e Crematory	02 01 09	R	eltsville.	MD					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	01443 22	. Name and Address of Fa	facility Cafa/S	Stepher	D. Lohrn	nann, P.A.					
			200 Port Sitter		3717 Green F			Baltimore						
	Dhamiring		23a. Part1. Ent			h as cardiac or resp	iratory arrest,		Approximate Interval Between Onset and Death					
	Physician /Medical		disease or condition resulting in death)	cons uence of):	- Cur				5 months					
	Examiner		1 - 2 1 - 2	Deren	dur Di	beter			year,					
	ed sit	iner	Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or Injury that initiated events  C. Hyperbolic Cause (Disease or Injury that initiated events)											
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68760,	rificate be executed g physician and as the burial-transit	edical	d											
89 x			IF FEMALE:											
Вох	eath cert attending I for use a	Physician/N	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	Ectopic pregnancy			23d. Date of deliv	very Day Year					
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>	ysicia is cert direct	To Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatient	Other	lace of Death (Chec	4	6 ☐Other (Speci	ihr)					
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<u> </u>	ttendl death. stor: A	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 388 Blace of injure	At home form stre	M 1 ☐ Yes 2									
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	0 2 0 =		29a. Certifier 1 Certifying Physician: To the best of	my knowledge, death	occurred at the time, date	e and place, and du	e to the cause	e(s) and manner as	stated.					
	To the Hos within 24 ho To the Fun completely f	Medical	one) and manner state	ed.										
	0 1 wit		29b. Signature and title of certifier		D S Q Z		29d. [	Date signed (Month,	Day, Year)					
7		-	30. Name and address of person who completed cause of dea	th (Item 23a) (Type. P				1 - 11 0	0					
	ax \		Bahader Mameni, ma	2 860	1 Vetero	ons Hwy	Sud	: 211	Mos colla					
	Stat Registra	.~	31. Date filed (Month, Day, Year) 32. Registrar	s Signature	P									

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryland		artment of H		and M		giene Reg. No.	2008	02426
3	Physici	an	1. Decedent's Name (First, Middle, La	st)						2. Date of Dea		Year	3. Time of Death
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	Examir	ner								County of Dea			
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	Funeral Director		250-32-9920	M 2□F	82	Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day 12/25/19	, Year) 225	J. Co	thplace (State or Foreign ountry)
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	laryla shov	5	10a. State 10b. County			Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 No
	the N 28a-f	recto	MD Anne Ar 10e. Street and Number	undel	0den	ton	10f. Zip Code				10a Citia	en of What Co	
	3a or	Funeral Director	207 Cannon Ball Way	,			2111.3	}			rog. Onz		ound y :
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98	or ite	y Fu	1 Never Married Married	1 X Yes 2 N If Yes, Give	lo	- 1	i res, specily cuba I□Yes 2√□No	Specify:	i, Puerto r	tican, etc.)		Black, White African	n-American
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yla	ould by Mental M	P	Alfred Derrien					Mary	Derrie	n			
Mar	12 sh hand 7 Ism traum		19a. Informant's Name/Relationship (	Type. Print)			g Address (Street a					Town, State,	Zip Code)
e,	1 and Healt tem 2	9	Helen Derrien/Wife  20a. Method of Disposition		20b. Pla	ce of Dispo	Cannon Ball sition (Name of natory or other place	Way, (		n, MD 21		ation - City or	Town State
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other ( <i>Specit</i>		Balti	netery, cren more: N	natorý or other placi at 1. Cemetei	e) YV	2-4-07	,		more, M	•
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical	(Check only one)	ysician: To the best on niner: On the basis of and manner state	examinatio	n and/or inv	estigation, in my op	ie, date an pinion, dea	d place, a th occurre	d at the time, d	ause(s) a late and p	and manner as place, and due	s stated. e to the cause(s)
	within To th comp	Me	29b. Signature and title of certifier				29c. License	number		2		signed (Mont	
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	941	ļ	30. Name and address of person who	completed cause of de	ath (Item 2	3a) (Type F	Print)	11 0	TP .		àrar	12014	M
	1		30. Name and address of person who was considered and address of person who wa	32. Registral	r's Signatur	s O	י לכוושמ	40	11	1	<i>ڪيا د</i> ر	110011	20770
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $27^{\text{Day}}$ **Physician** 2008 Year David Conrad Dash 11:11 a<sup>M</sup> January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 429 Maryland Avenue Baltimore Catonsville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Mark | Ma 5. Social Security Number 216-58-2897 7. Age (*In yrs. l*as*t birthd*ay). 54 Yrs. 9. Birthplace (State or Foreign **Funeral** Maryland 1 XM 2 ☐ F **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 ☐XNo Baltimore Catonsville **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 429 Maryland Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give 71-77 Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electric Technician Amusement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara Mae Faulkner Roy Adam Dash 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Karen Dash - Wife 429 Maryland Ave., Catonsville, MD 21228 20b. Place of Disposition (Name of cempetery, crematory or other place)

Meadowridge Memorial 1-30-2008

Park 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or Elkridge, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signafure of Funeral Service Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic mmediate Cause (Final Breast months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit /gg Due to (or as a consequence of): or Vital Records, P.O. Box 68760, attending physician for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page this certificate 1□ Yes 2 or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Division 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) D16354 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

JAN 3 1 2008

32. Registrar's Signature

STAGNES 900 CATON AVE BALTIMORE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:40 PM M January 21, 2008 Isabel Dickinson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Takoma Park Sligo Creek Nursing & Rehab If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/09/1910 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) NJ Country) **Funeral** Months Days Hours 1 □ M 2 🕱 F 97 136-09-0917 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or Items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Directo Takoma Park MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20912-7525 Carroll Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Midowed 4 Divorced 'natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Government Elementary/Secondary (0-12) College (1-4or 5+) Librarian Health and Mental Hygic tem 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Mulford Frank Bower L<sub>o</sub> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 807 Langley Drive Silver Spring, MD 20901-Lucille Dickinson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itel
any injury or otl 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses M00382 Rapp Funeral & Cremation Services Stiple Dahman 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-tran Box 68760, attending physician 9 Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 mont 1 □ Yes 2 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 M Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending 1 Yes death. investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu

29a. Certifier 29b. Signature and title of certifier

(Check only one)

29c. License number D46998

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 3415 HAMILTON ST#1 HYA + HAVILL MD 20782
32. Registrar's Signature

State Registrar

31. Date filed (Month, Day, Year) 3

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jan. 29, 2008 5:00 A-M inser /Medical titution, give street and number 4a. Facility Name (If not in. 4b. City, Town, or Location of Death 4c. County of Death Examiner 5235 tredcrest Baltimore 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **250-36-68** Age (In yrs. last birthday, 8. Date of Birth 04. 01. 192. Birthplace (State or Foreign Country) **Funeral** 6885 80 Yrs. Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 Yes 2 □ No Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: ģ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use letired) Elementary/Seconda dary (0-12) College (1-4or 5+) Handler 7 is marked other traumatic event, t irst, Middle, Maiden Surname. Be Health and Mental DSE. 2 a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Ear Item 27 i mD 21229 comona 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once, 1X Burial 2 ☐ Cremation 3 Removal from State Owings Mills 2.1.2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur o Funeral Service Live 4:16; Nat 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final months **Physician** disease or condition resulting in death) MNG cancer /Medical Due to (or A consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed and attending physician a for use as the burial-Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an s certificate has t lirector, page 2 s autopsy performed? Yes 2 No 1□ Yes ours after death.

leral Director: After this certifier filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Matural 2 ☐ Accident 5 ☐ Pending investigation 1 🗌 Yes 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated. To the ! 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DS alim D60203 UNA MP January 30, 2008 30. Name and address of person who com eted cause death (Item 23a) (Type, Print) Baltimore, 21231 Street Johns Hopkins CRB1-186 Maryland Rosalyn Juergens 1650 Orleans 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

08-00730 Harry W. Eckman

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

arry TV. Lowne		1- For State Certificate of De Registrar Certificate of De		Reg. No	200	8 0243
Physicia	n/	1. Decedent's Name (First, Middle,Last)	2.	Date of Death		3. Time of Death 1935 hrs
ledical Examii	ner		ity, Town, or Location of Death	Month Day January 26, 20	c. County of Death	1935 1115
			altimore		Worcester	
Funeral Director			lonths Days Hours Min	8. Date of Birth(MN December 2,	VDD/YYYY) 9. Birth Foreign 1959 Cour	Maryland
21215-0036 Muld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f show any c event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Worcester  10c. City, Town or Location  Beclin  10e. Street and Number  544 Bay Street  11. Manital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No  11 Yes, S  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  17. Father's Name (First, Middle, Last)  Hacold Eckman  19a. Informant's Name/Relationship (Type, Print)  Ronald Eckman / Brother  20a. Method of Disposition  10c. City, Town or Location  11d. Was Decedent Ever in U.S.  11 Yes 2 No  12 Yes  13. Was Decedent Ever in U.S.  14. Yes  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Uduring most of during most of the complete of t	E. Zip Code  2 (81)  cedent of Hispanic Origin? (Spec pecify Cuban, Mexican, Puerto Rise 2 × No specify:  sual Occupation (Give kind of work for working life. DO NOT use retired Mechanic  18. Mother's Name (F	ify Yes or Nocan, etc.)  k done 16b.  irrst, Middle, Maide  irrst, Middle, Maide  irrst, Middle, Maide  irrst, Middle, Maide  irrst, Middle, Maide	tizen of What Count  U.S.A.  14. Race - America White, etc.  Specify: White Kind of Business/In  Auto Re  n Surname)  City or Town, State,	an Indian, Black,  and Gustry  Zip Code)
Baltimore, MD permit Pages 1 and 2 she Department of Health and Important: If item 27 is injury or other traumati		7522	s Registry January and Address of Facility Anat Connelley Drive	Suite P. F	lanover, M	D 21076
Physician Medical caminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):  b.	ode of dying, such as cardiac or re	espiratory arrest, sl	nock, or heart	Approximate Interval Between Onset and Death
Box 68760, cleath certificate be executed the attending physician and edfor use as the burial - transit	Physician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that immated events resulting in death) Last  UNPENDED  Due to (or as a consequence of):  d.  AMENDED  IF FEMALE:  23c. If yes, outcome of pregnancy	eath 3 Ectopic pregnanc		3d. Date of delivery Month Da	ay Year
P.O. es that the gned by the detache	Completed by		rlying cause given in Part I.  26.Place of Death (Check on	1 Yes 2  24a. Was an autopsy performed  1 Yes 2	prior to co death?	opsy findings available impletion of cause of
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	ation: To Be	1 Ves 2 No Inpatient 2 ER/Outpatient 3	28c. Injury at Work?  1 Yes 2 No	8d. Describe how it edestrian struc	ck by auto	Doub Newton City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ical Certification:		Fr at the time, date and place, and di	or Town, State) ranklin St and Rt ue to the cause(s) a	113, Berlin, MD	al Route Number, City  d. cause(s)
To the within To the comp	Medical	30. Name and address of person who completed cause of death (Item 23a)	29c. License number O.C.M.E.  1 Penn Street, Baltimore,	290 Ja	Date signed (Monnuary 27, 2008)	th, Day, Year)
	ate		2 9			
Regist  DHMH 17 Rev 1/20	_	JAN J. AND J. See J. J.	<i></i>			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) O Z 10:55 AM **Physician** 25 Kichard Wendell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
GOOD SAMARITAN HOSP 4b. City, Town, or Location of Death Examiner HOSPITAL Baltimore NIA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours 1 M 2□F 019-22-6966 Octobe-9, 1932 MASSACHUSZHS Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State ral', or items 23a or 28s-f ehov Exercicer must be notified at 1 XYes 2 □ No Baltimore Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Apt. E 21212 USA Ave. 5846 Bellona Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If term 27 is marked other thermal eny Injury or other treum... 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates: Kurean Was 3 ☐ Widowed 4 M Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Research Director 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mercy Carley Wendell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alison Fogg 15 Bridge St. Oxford OXII OBA United Kingdom Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry January 24,2008 Hanover, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility An actomy Gifts Registry 1522 Connelley Drive Suite P. Hanever, MD 21076 21. Signature of Funeral Service Licensee 23a. Part1. Enter the cisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2/2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To Inpatient 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 12 Conflying Physician: To the bast of my knowledge death coruned at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES 000 Jasaeva 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 148

Registrar DHMH 17 Rev 1/2001

State

GSH 32. Registrar's Signature

ELENA

31. Date filed (Month, Day, Year)

JAN 3 1

5601 LOCH RAVEN BLVD, BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 25, 2008 8:30 A Jan. Betty Lou Fortinberry /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Hospice Center **Baltimore** Towson 8. Date of Birth (Month, Day, Year) 05.07.1929 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🕱 F 78 GA 260.38.0300 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits la or 28a-f show t be notified at 1 ☐ Yes 2 No MD Baltimore Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 15208 Priceville Road 21152 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examiner must U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No 3altimore, Maryland 21215-0036 White Specify: 2 3. Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Attorney's Office Receptionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Brown Tommie Lee James 19a. Informant's Name/Relationship (Type. Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane C. Meileinggaard/ 15208 Priceville Road, Sparks, MD 21152 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 01.29.08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cafa/Stephen D. Lohrmann P.A. 21. Signature of Funeral Service Licensee 8717 Green Pastures Drive, Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (orks a consequence of): PAVS Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi Due to (or as a consequence of): O. Box 68760, physician Physician/Medical the ate has been signed by the attending p page 2 should be detached for use as: IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 1 No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow ٠σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPLA 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Mapner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attendl 4 hours after death. Funeral Director: A ely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Chinles ST TONSON MO 21204 HARRES 6701 W

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

889

1/25/08

Fortinberry, Betty

32. Registrar's Signature

State Registrar Amend 19a, perFH, g875, 2/5/08 TT Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Joan Inez Gallagher 30 JUNUERY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Burnie 61en altimore Washington Medical Center 8. Date of Birth (Month, Day, Sept 8, If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** Months Days Hours Min 1 M 2 X F 191-34-6012 65 Director Usual Residence of Decedent 10c. City, Town or Location 72 hours after death with the Maryland 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Directo Severn Anne Arundel Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21144 1317 Ava Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No 21215-0036 Specify. Be Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7/sith and Mental Hygiene.
7 is marked other than "n College (1-4or 5+) Elementary/Secondary (0-12) Income Tax Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Inez Pearl Stitzinger Bruce Brooks Gibbons Gallagher Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print)
Cheryl Schaffer, Step-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other tra once. 700 Main Street Royersford, Penna. 19468 Step-Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 01/31/08 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequent e of): Examiner Kes phil at Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner the death certificate be executed the burial-transi attending physician and (or as a consequence of) Division or Vital Records, P.O. Box 687607 as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown should 24a. Was an page 2 s autopsy performed? Yes 2 No has 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of De th 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funera 5 Pending investigation Injury or Attending 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide To the Hospital 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signalure and title of ceptified 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 GAM 32 Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Year

Arunde

Pennsylvania

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Jauro

1 ☐ Yes 2 No

2008

USA

14. Race - American Indian,

Black, White, etc.

Specify: White

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No

Month

DHMH 17 Rev 1/2001

State Registrar 08-00790 Joshua Dennis Gibson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 02434

Silva Dellilla Ci		For State	0.	ato of	11101 710	(	Certific	ate of	Death					Reg. No.			0 (	1440
Physiciar		e <b>gistrar</b> . Decedent's Name	e (First, Midd	le,Last)									Date of De Month	Day	Year		Time of De 2146 hrs	
edical Examin	.,	Joshua			Denn	is			Gibso				January	28, 20			2 140 1113	<u> </u>
		a. Facility Name (i	f not institution	on, give str	eet and nu	mber)		41	. City, Tov		ocation of	Death			c. County of Baltimore		J	
		Church Roa	id @ Seai	rles Roa	d				Dundall									OF.
Funeral	5	. Social Security N	Number	6. Sex		7. Age (In	yrs. last bir	thday)	If Under	1 Year Days	If Under	1.00	8. Date of E			roleigii		_
Director		219-31-4	887	1 Хм	2 F		16	Yrs.	Monuis	Days	riouis	,,,,,,,,	April	4,1	991	Countr	y) Mary	Ziand
	h	Jsual Residence o	f Decedent													110	od. Inside C	City Limits
any	1	0a. State	10b. County			10c	City, Towr										Yes	
how Ee.		MD.	Balt	timor	e		Du	ındall										- 34
Maryland 28a-f show any datonce	읽	10e. Street and Nu	ımber						10f. Zip C	code				10g. Ci	tizen of Wh	at Country	'?	
or 2	Director	7802 Mea	ath Roa	ad						1222					USA			
death with the Maryland or items 23a or 28a-f sho must be notified at once.		11. Marital Status				cedent Eve	r in U.S.	13. Wa	s Decedent es, specify	t of Hisp	anic Origi	n? (Spe	cify Yes or	No-		- Americar e, etc.	n Indian, Bi	аск,
item	Funeral	1 X Never Marr	ied 2	Married	Armed F	2 X	No	1								White	2	
Ter de		3 Widowed	4 D	ivorced	Yes, Give Ye	ar								lack.	. Kind of Bu			
136 thin 72 hours after te. than "natural", edical Examiner	핡	15. Decedent's E	ducation (Sp	ecify only	highest gra	de comple	ed) 16a	. Deceden during m	t's Usual O	ccupations in a life.	on (Give k DO NOT u	ind of wo	ork done ed)	100	. King of bu	isii tess/ii tu	ustry	
72 ho	Completed	Elementary/Sec	ondary (0-12	2)	College (	1-4 or 5+)								-	ast E	I boos	Posta	urant
within 7. iene.	립	10 years	3					Coo	k	- 14	0 Mother's	e Name	(First, Midd	e Maide	ast r	)	Nes ca	urane
5-0036 iled within 7 Hygiene.		17. Father's Name								- [			nele G					
21215-00. Duld be filed with I Mental Hygiene is marked other tic event, the Me	a	Mark Dav			5:12		- 1	Oh Mailin	Address	(Street	t and Num	ber or R	ural Route	Number,	City or Tov	vn, State, Z	Zip Code)	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other transmatic event, the Medical Examiner must be notified at once	유	19a. Informant's N				+hor							dalk,M			2122		
MD id 2 sho lith and m 27 is aumat	1	Peggy G: 20a. Method of Di		GI	andmo	Julei	20b. Place		sition (Nam				Date Cuary	20	c. Location	- City or To	own, State	
15 E E E		1 X Burial 2	Cremati	ion 3	Removal	from State	crem	atory or of	her place) Ceme				2008	M:	ill Cı	ceek,	WV.	
Page Page nent ant:		4 Donation	5 Other	Specify:			beru											
Baltimore, permit. Pages I an Department of He Important: If ite		21 Signature of F	uneral Servi	ce License	<b>1</b>	- 0	D.,	22	onne l	ΊΫ́	Funer	al I	Home C	of Di	unda II	K,P.A	2122	2
<b>m</b> 80 = 1		Juth	my		of N	caused the	death Do	not enter	the mode o	of dying,	such as c	ardiac o	Roac r respiratory	arrest,	shock, or h	eart	Approxim	ate Interval Onset and
Physician		23a. Part I. Enter failure. List	only one cau	ise on each	n line.	oaasoa are												eath
* ************************************		Immediate Cause or condition resu	e (Final disea	<sub>ase a.</sub> N	fultiple G	Sunshot S	vvounas											
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	들	rouse Enter Un (Disease or injur	derlyin Cau y that initiate			s a consequ	iones of):			_	_	_		_				
ed sait	Examine	events resulting	in death) La	st D	ue to (or as	s a consequ	Jence Or).											
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760, cate be executed physician and he burial - transit	Medical					s, outcome	of pregnar	ncv	_			_			23d. Date	of delivery		
376 ficate g phy s the	Z/	IF FEMALE: 23b. Was decede		in the		e birth	or program		etal death	3	Ectop	ic pregn	ancy		Month	D	ay	Year
Ox 687( eath certifica e attending pl	sician/	past 12 mon			T	egnant at tir	ne of death	5 (	Other (Spe	ecify)				- 10	ii.			
Box 687 e death certifice the attending p	Phys		No 9			known		dain min da da d	undorlying	a called	given in P	Part I	23e.	Did toba	cco use cor	ntribute to	the cause	of death?
at the etache	y P	Part II. Other sig	gnificant co	nditions	contributin	g to death I	out not resu	uting in the	undenying	y cause	giveniiii	urt ii						Unknown
, P ires the signe lbe d	Q p												24a.	Was an	24	. Were au	topsy findii	ngs available
rds requ	ete													autopsy performe	ed?	prior to c death?	:ompletion	of cause of
SCO ne law te has	Completed by													Yes 2		1 🗸 Ye	es 2	No No
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	ပြို		eferred to me	dical			100			_	-		conly one)			. I d ou	- Cc	
<b>/ita</b> /sicin nis cer direct	o Be	examiner? 1 ✓ Yes	2 No	Н	ospital: 1	Inpatien		R/Outpatie		DOA	Other <sub>4</sub>		ing Home		esidence (		r: Scene	
of \ of \ g Phy fler therefore and \( \text{neral} \)	Ę	27 Manner of D			28a. D	ate of Injur onth Day Ye 28, 2008	y 2 ar) 2	8b. Time (	of Injury		jury at Wo		Subject	cnbe no S <b>hot</b>	w injury occ	uneu		
ath.	Ę.	1 Natural		Pending Investigation				0000 hrs		-	Yes 2					D. D.	nel Bouto	Number City
risio	fica	2 Acciden	• []	Could not I	28e. F	Place of Inju	ry - At hom	ne, farm, st	reet, factor	ry, office	building,	etc.	28f. Loca or To	tion (Str own, Sta	eet and Nu te) Searles Ro	mber or Ku	Jrai Roule	Number, City
ital of Ira	Certification:	4 V Homicio		determined	Spec	ify) Loc												
Division  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the:	) <del> </del>		Certifyir  Medical	ng Physici	an: To the	best of my	knowledge	e, death oc	curred at th	ne time,	date and p	place, ai	nd due to the	e cause( . date ar	(s) and man nd place, ar	ner as stat n <b>d due to</b> th	.ea. ne cause(s	)
o the ithin o the	Medical				On the ba and mann	isis of exam er_stated.	ination and	J/OF Investi			nse numbe				29d. Date s	igned (Mo	onth, Day,	rear)
E » F »	Z Z	29b. Signature	and title of co				_		2			ei			January			,
		1	my			wi				U.C	C.M.E.				January			
1		30. Name and	address of pe	erson who	completed	cause of d	eath (Item 2	23a)	and Del	timore	MDS	1201						
5		Ling Li, N				xaminer			reet, Bal	ULLIOLE	, IVID Z	1201						
	State					2 Registrar	s Signatur	e A										
Regi	stra	r	JAN 3	1 20		Course de la constitución de la	1 30	A STATE OF THE PARTY OF THE PAR	A STATE OF THE PARTY OF THE PAR				_	ONE				
DHMH 17 Rev 1	/2001	ı						ÖRİĞII	NAL.				U	CME				

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

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Fleas	e Type or Prin State of Ma								-egible.	
For State	Otate of Me			ificate of			лентат пу	giene	<b>6</b> de la	
Registrar			Jen	ilicale oi	Dealli			Reg. No.	200	8.0213
Decedent's Name (First, Middle,	,	_					Date of De     Month	eath Day	Year	3. Time of Death
	Billíe	Eugene	Ge	orge			01	2	1 2008	8 04:10 AM
4a Facility Name (If not institution, of	give street and number)	tal Cent	4	4b. City, Town, o	Location	of Death		4c. (	Bounty of Dea	mare
5. Social Security Number 6		(In yrs. last birth		If Under 1 Year Months Days	If Under Hours		8. Date of Bi	rth	9. Bir	thplace (State or Foreign
215-28-1088	M□M 2□F 7	7Y	rs.	Widitins Days	Hours	Min.	July 2	- '	1	ountry) rginia
Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	0 1 0 0 0	41						
Toa. State		TOC. CRY, TOWIT	or Loca	RION						10d. Inside City Limits
PA . Y	ork Co.			Faw	n Gro	ve				1 ☐ Yes 2 No
10e. Street and Number				10f. Zip Code				10g. Citiz	en of What Co	ountry?
387 Deer Road				17321				Uni	ted St	ates
11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. W	as Decedent of H Yes, specify Cuba	ispanic Ori	gin? (Sp	ecify Yes or No		4. Race - Ame	erican Indian,
1 ☐ Never Married 2 Married	1 ∑Yes 2 N	0				i, Fuerto	nican, etc.)		Black, Whit	te, etc.
3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1	951-54	1 L	□Yes ŽEŽNo	Specify:				Specify:	White
15. Decedent's (Specify only highest of	Education grade completed)	16a. [	ecede	nt's Usual Occup	ation	t of work	ina	16b. Kin	d of Business	
Elementary/Secondary (0-12)	College (1-4or 5-		life. DC	NOT use retired	1)		9			
12 Years		Qua	alit	y Assur	ance			Wes	tern E	lectric Co.
17. Father's Name (First, Middle, La	st)					r's Name	(First, Middle			
Elmer Geor	:ge					M	yrtle v	Viers		
19a. Informant's Name/Relationship	(Type. Print)	19b. I	Mailing	Address (Street	and Numbe	er or Rura	al Route Numb	er, City or	Town, State,	Zip Code)
Mrs. Lillian S.	George (Wi			Deer Ro			Grove,			
20a. Method of Disposition	_	20b. Place of E	Disposit	ion (Name of tory or other place	a)		Date	20c. Loc	ation - City or	Town, State
1 ☑ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spec		1		Faith C	· .	1/30	/2008	Ва	ltimore	e, Maryland
21. Signature of Funeral Service Lic	_Call	)	I	Name and Addres Ouda-Ruc 7922 Wis	k Fun se Av	eral e. ]	Dundalk	of Du	ndalk,	Inc. 21222
23a. Fifth Enter the disease, or co shock, or heart failure. List on	mplications that caused t ly one cau = on each line	the death. Do no	t enter	the mode of dyin	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between

Approximate Interval Between Onset and Death

29d. Date signed (Month, Day, Year)

Balto.

**Physician** /Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

1 - For State Registrar

Immediate Cause (Final disease or condition resulting in death)

GIZAWH. WOLDETHWOT

2008

31. Date filed (Month, Day, Year)

JAN 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**Physician** /Medical

Examiner

Director

Funeral

Completed by

To Be

**Funeral** Director

Examiner

signed by the attending physician and detached for use as the burial-transit should peen cate has by page 2 s

Examiner Medical Certification: To Be Completed by Physician/Medical within 24 hours after death.

To the Funeral Director; After this certificate I completely filled in by the funeral director, pag

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		opic pregnancy er (specify)		23d. Date of de Month	livery Day	Year
Part II. Other significant conditions con	ntributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did tobacco			of death? □Unknown
COPD arte	ry disease		24a. Was an autopsy performed ∕1 Yes 2 🗖 N	death?	utopsy findii completion 2 \( \text{No}	ngs available of cause of
25. Was case referred to medical examiner?	/	26. Place of Death	(Check only one)			
1 ☐ Yes 2 ☑ No	lospital: 1 Inpatient 2 ☐ ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing Hon	ne 5 Residence	6 ☐Other (Spe	cify)	
27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at 2 Work?	8d. Describe how inj			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, f building, etc. (Specify)	actory, office 2	8f. Location (Street a City or Town, Sta	and Number or Ri	ural Route I	Vumber,
29a. Certifier (Check only one) 1 ☑ Certifying Phys 2 ☐ Medical Examin	icician: To the best of my knowledge, death occ ner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, a gation, in my opinion, death occurre	and due to the cause( ed at the time, date a	s) and manner as nd place, and due	stated. to the cau	se(s)
29b. Signature and title of certifier		29c. License number	29d. D.	ate signed (Mont	h Day Yea	(r)

Due to or as a consequence of):

DHMH 17 Rev 1/2001

State

Registrar

9000

32 Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Day Year Alberta D. Gerlock 26, 5:48P M January 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 4207 Riversedge Way Dundalk Baltimore Co. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 13 F Director Vrs 220-01-6232 90 April 17,1917 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 28a-f show 10d. Inside City Limits ner must be notified at Director Maryland Baltimore Dundalk 1 □Yes Ži⊓No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 items 23a 4207 Riversedge Way 21222 Funeral United States Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify. 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. tem 27 is marked other than 12 Years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Boddice Hazel Campbell ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4207 Riversedge Way Beverly L. Rich (Daughter) Dundalk, Maryland 21222 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 14 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 1/30/2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. a 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ingestive their disease or condition resulting in death) Comes /Medical Due to (or as a consequence of) Examiner Hyperten suce Atherositarita Cardiovinion Misery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. pe o 2 No 1 Tyes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an certificate has t irector, page 2 s autopsy performed21 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA nours after death. neral Director: After this villed in by the funeral di 5 Residence 6 ☐Other (Specify) this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C completely filled CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State Registrar 29b. Signature and title of certifier

Mobert Durt

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

To the

Kowt

A seath

29c. License number

ld heltimore, MD

29d. Date signed (Month, Day, Year)

and manner stated.

North

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #7&8 perFH g876, 2/7/08 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 20<u>08</u> Physician 28 Leatha E. Gosnell 1 11:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Nursing Home- Homewood N/A Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M & 1 220-12-8208 Director 82 8-30-<del>1922</del> **1925** Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant; If item 27 is marked other than "natural;", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Maryland N/A 1XXYes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3655 Keystone Avenue 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Never Married 1 Married Maryland 21215-0036 1 ☐ Yes 2 XXIIIo Specify þ Specify 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unknown Homemaker In own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 should be fill nt of Health and Mental H it If item 27 is marked oth Be George Kimmel Alma Rohrback 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel A. Gosnell 3655 Keystone Avenue Baltimore, Maryland 21211 Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Vteran Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If at Garrison Forest 2/4/2008 Owings Mills, M

22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, Maryland 21211 4 ☐ Donation \_ 5 ☐ Other (Specify) Owings Mills, MD 21. Signature of Funeral Service Lidens any shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final nelalatu Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Due to (or a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit Due to (or as of nsequence of) Division or Vital Records, P.O. Box 68760, Hyperle Physician/Medical as attending IF FEMALE for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) the 9 ☐ Unknown by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ge 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page autopsy perfor 1☐ Yes certificate 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1 No 1 Inpatient ၉ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28h Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After or Attending 5 Pending investigation (Month, Day Year) 1 Natural 4 hours after death.
Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Vithin 24 hours and To the Funeral Dir To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3146 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. ENTAWAF Soute 208 BALTIMOREMI) 2126 HAStoni MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 3 2008 Registrar

DHMH 17 Rev 1/2001

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036 **Physician** /Medical **Examiner** physician and s the burial-trans Division or Vital Records, P.O. Box 68760, attending phase as the signed by the period of the details page 2 should After this filled in by within 24 hours a To the Funeral I

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

**Funeral** 

Director

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 4 ☐ Homicide 29a. Certifier 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 921 N. EMAN ST INTE 308, BALTINOREMD

State Registrar

31. Date filed (Month, Day,

HASHMI 32 Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F			iene	0.0	00100
4	Physici /Medic		1. Decedent's Name (First, Middle ROSE Got	Hieb				2. Date of Deat	h Day 2		3. Time of Death  OS. JOAM
	Examin	er 	4a. Facility Name (If not institution ANNE ARUNDEL	MEDICAL CENT		ANNA	POLIS  If Under 24 Hrs.		1	IE ARUI	
Apr.	Funeral Director		5. Social Security Number 213-34-6021 Usual Residence of Decedent	6. Sex 1 ☐ M 2 💢 F	70 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 03/23/	1937	9. Birthplac Country	MD
	Maryland -1 show	tor	10a. State 10b. County	E ARUNDEL	10c. City, Town or L					100	I. Inside City Limits  1 Yes 2 No
	th the	Director	10e. Street and Number		0.10110	10f. Zip Code		1	0g. Citizen of \	What Country	13
	ath wi	ral	5508 BERKLEY				20733			USA	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I Health and Mental Hygiene. It has 23 or 28a-f show other traumatic event, the Marylaal Exandrat must be restlined.	by Funeral	11. Marital Status  1 Never Married 2 Marria  3 Widowed 4 Divorced	If Yes Give	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cubin 1 Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)		e - American ck, White, etc	
2-0	72 ho	eted		t's Education st grade completed)	(Give	dent's Usual Decup	during most of works	ng	16b. Kind of B	usiness/Indu	stry
21215-0036	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 9	5+}	FIED MED	CAL ASSIS	TANT	M	1EDI CAI	L
Maryland	should be filed and Mental Hygis marked other umatic event, L	To Be (	17. Father's Name (First, Middle, HERMAN	Last)	АР	PEL	18. Mother's Name	(First, Middle, i	Maiden Suman	ZUL\	VER
	1 and 2 sho Health and 1 16m 27 is mu		19a. Informant's Name/Relations JODYE ROBEY /				and Number or Rura  / MANOR LA		•		20733
Baltimore,	90==		20a. Method of Disposition  1			osition (Name of matory or other pla- RE HEBREV	ce)	/2008	20c. Location -		
Balt	permit. Pag Depertment Important:: eny injury c		21. Signature of Funeral Service	Georgeo Duiger	2	2. Name and Address 8900 RE	SISTERSTOWN	OL LEVI   ROAD -			
1	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Topper Due to (or as Due to (or as c. RLCUA	a consequence of):  Acad Sh a consequence of):  Acad Sh Consequence of):  Acad Sh	ter the mode of dying a Value of Value	ng, such as cardiac o VF ABSCE LTS bacterer	or respiratory arr	est,	11	Approximate nterval Between Onset and Death
68760,	ficate be executed physician and s the burial-transit	dlcai		d	a consequence of):						
O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 \( \text{Live birth} \) 4 \( \text{Pregnant a} \) 9 \( \text{Unknown} \)	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у			ite of delivery onth D	/ Pay Year
rds, P.	w requires that been signed b should be dete	þ	Part II. Other significant conditions and improparties	ons contributing to death by Commen	out not resulting in the	underlying cause gr	ven in Part I.		bacco use con		cause of death?
Vital Records,		Completed	End Stay & Dena	L disease	byperlipi	dialy5	5,	24a. Was a autops perform	med?	prior to comp death?	sy findings available pletion of cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case reterred to medica examiner?				26. Place of Death	(Check only or	ne)		
of	Phys this ral di	: To	1 ☐ Yes 2 No  27. Magner of Death	Hospital: 1 Inpati		III 30 DOX	ner: 4 ☐ Nursing Ho	me 5 Resid			
vision	tending leath. tor; After the fune	tification:	1 Natural 5 Pendir 2 Accident Investi 3 Suicide 6 Could	gation not be 280 Place of to	ny Year) Injury	M 1	Yes 2 □No				Davie Abus -
≥	or At ter of irect	ŧ	4 Homicide determ	nined 289. Place of In	jury - At home, farm, si tc. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tow		oer or Hural I	HOUSE NUMBER,

State Registrar

Medical Ce

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Denz 2001 Medical Parhway

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physicia		Registrar  1. Decedent's Name (First, Middle, Last)			tenificate of		2	. Date of De.		V	3. Time of Death
/Medic		CAROLYN	JANET	HOFMANN			J	Month Sanuary	Day 26	Year 2008	1:38 p <sup>M</sup>
Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of	f Death			unty of Deatl	
		HARFORD MEMORIA				DE GR				ARFORI	
Funeral Director		5. Social Security Number 6. Sex 10 10 10 10 10 10 10 10 10 10 10 10 10	M 2XX	(In yrs. last birth) 69 Yt	Months Davs		Min.	Date of Bird (Month, Da pril	y, Year)	Co	nplace (State or Foreign untry) EW YORK
		Usual Residence of Decedent						prii -	11 133		
r 28a-f show	_	10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits 1 ☐ Yes 2 No
allito	ecto	MARYLAND HARFORD	CO		ABERDE	EN			10= Ciri	-( \\/\ \ O -	
3	ä	10e. Street and Number			10f. Zip Code	0.1			10g. Citizen	S.A.	untry?
	Funeral Director	1902 PERRYMAN ROAI	12. Was Decedent Ev	er in U.S.	13. Was Decedent of If Yes, specify Cub		jin? (Speci	ify Yes or No		Race - Ame	
	Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X☐No If Yes, Give	,	If Yes, specify Cub		, Puerto Ri	can, etc.)		Black, White	
i	d by	3 ☐Widowed 4 □ Divorced	Year or Dates:							ъсу. Вы	<del>YG</del> K
	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. C	Decedent's Usual Occu Give kind of work done life. DO NOT use retire	pation during most	of working	7	16b. Kind o	of Business/	ndustry
	шо	Elementary/Secondary (0-12) 8th grade	College (1-4or 5+	)	CAREGIVER	,,,			ASSIS	TANT	LIVING
	BeC	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name (	First, Middle	Maiden Sur	mame)	*
	ToE	HAROLD ERTWINE				GLA	DYS E	ERTWIN	E		
1		19a. Informant's Name/Relationship (Ty)	pe, Print)		Mailing Address (Stree						(ip Code)
		Joe Delottenville, 20a. Method of Disposition	/Son		02 Perryma		Aber			ion - City or	Town State
once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State		Disposition (Name of crematory or other pla	1					•-
		4 □ Donation 5 □ Other (Specify)  21. Signs are of Funeral Service Licens	· ·	METRO	CREMATORY  22 Name and Addr		2-05-				MARYLAND
once		Mas bear of	was								RFORD, P.A. , MD 21001
	Ţ	23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused t	he death. Do no	h						Approximate Interval Between
the bur	ledicai Examiner	Gequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of	•						
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	3c. If yes, outcome o 1 □Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	;y			23d	. Date of del Month	ivery Day Year
in an annual series	þ	Part II. Other significant conditions cor Diabetes	ntributing to death but	not resulting in t	the underlying cause g	ven in Part I.			obacco use Yes 2□N		the cause of death?
N .	Completed						_	24a. Was auto perfo 1 \( \text{Yes} \)		4b. Were au prior to death?	topsy findings available completion of cause of
, page	ပ			W	-5	hor		Check only			
actor, pag	Be	25. Was case referred to medical examiner?	lospital:		patient 3 DOA	4 ∐ Nu		e 5 ☐ Resi	how injury o		city)
8	To Be	examiner? 1 Yes 2 No	1 Unpatien			iry at	20	d. Describe			
	To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1  Inpatien 28a. Date of Injury (Month, Day		me of 28c. Inju	ıryat ork? ∐Yes 2.∐l		d. Describe			
neral d	Certification: To Be	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a Date of Injury (Month, Day	Year) 28b. Ti	me of 28c. Inju	Yes 2 🗆	No	3f. Location (	(Street and N wn, State)	lumber or Ri	ural Route Number,
neral d	edical Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined  29a. Certifier (Check only one)  1 Certifying Physical Examination (Check only one)	28a. Date of Injury (Month, Day)  28e. Place of Injury building, etc.	Year) 28b. Tii Inji y - At home, farr (Specify) imp knowledge, examination and	me of ury M 28c. Injury M 1 [ m, street, factory, office death occurred at the for investigation, in my	Yes 2	No 28	Bf. Location ( City or To	wn, State) cause(s) an date and pla	d manner as	s stated. to the cause(s)
neral d	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined  29a. Certifier 1 Certifying Phys. (Check only 2 Medical Examine)	28a. Date of Injury (Month, Day)  28e. Place of Injury building, etc.  sician: To the best of ner: On the basis of	Year) 28b. Tii Inji y - At home, farr (Specify) imp knowledge, examination and	me of ury M 28c. Injury W 1 [ m, street, factory, office death occurred at the for investigation, in my 29c. Licer	Yes 2	d place, ar	3f. Location ( City or To	cause(s) and date and place 29d. Date s	d manner as ace, and due igned (Mont	s stated. It to the cause(s)  h. Day, Year)
completely filled in by the funeral director, page 2	edical Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined  29a. Certifier (Check only one)  1 Certifying Physical Examination (Check only one)	28a. Date of Injury (Month, Day)  28e. Place of Injury building, etc.  sician: To the best of and manner state	Year) 28b. Tilling  Year)	me of ury M 28c. Injury M 1 [ m, street, factory, office death occurred at the for investigation, in my 29c. Licer	Yes 2	d place, ar	3f. Location ( City or To	wn, State) cause(s) an date and pla	d manner as ace, and due igned (Mont	s stated. to the cause(s) h, Day, Year)

08-00662 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Elaine Highduchek 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Elaine Highducheck **Medical Examiner** January 23, 2008 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Union Hospital Elkton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 6. Sex **Funeral** Months Days Hours 196-38-7529 52 Director M 2X F Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County MD Ceci1 Chesapeake City , or items 23a or 28a-f show r must be notified at once, Director 10e. Street and Number 10f. Zip Code 160 Basil Avenue, 21915 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 2X No Yes Yes 2 X No specify: Widowed Divorced If Yes, Give Year the Medical Examiner "natural". þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done wite Pages 1 and 2 should be filed within 72 hou. virment of Health and Mental Hygiene virant: If tiem 27 is marken or other free. Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12 Homemaker 17. Father's Name (First, Middle, Last) Howell **Helen** Roy Be ٩ 19a. Informant's Name/Relationship (Type, Print) Robert Highducheck / Husband 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition valley Memorial Park 1 XBurial 2 Cremation 3 X Removal from State Baltimo
permit. Page
Department of
Important: Other Specify Donation 5 of Funeral Service License **Physician** failure. List only one cause on each line /Medical Atherosclerotic cardiovascular disease Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED attending physician for use as the burial #23a,PII,27,perME,g876, 2/25/2008 TI 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✓ No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. þ Chronic alcohol use Completed page 2 should To the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical this

8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 10/11/1955 PA 10d. Inside City Limits Yes 2 XNo 10g. Citizen of What Country? USA 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc. White Specify: 16b. Kind of Business/Industry Own Home 18.Mother's Name (First, Middle, Maiden Surname) Slonecki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 160 Basil Avenue, Chesapeake City, MD 21915 20c. Location - City or Town, State 1/29/2008 Delmont, PA 22. Name and Address of Facility
Charles L. Stevens Funeral HomeInc
1501 East Fort Avenue, Baltimore, HomeInc. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death 23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✔ Yes 2 1 V Yes Be Other4 Hospital: 1 Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes ို 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 Pending 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. January 24, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State 2008

2008

4c. County of Death

3. Time of Death

1735 hrs

DHMH 17 Rev 1/2001

Registrar

OCME

After

within 24 hours after death.

To the Funeral Director: /
completely filled in by the fi

**ORIGINAL** 

			1 - For State Registrar	State of Maryland	_		of Death	vientai my	/gien Reg. N	Z 11 11 16	02442
W. Company	Physic /Medi		1. Decedent's Name (First, Middle, Last)		ephine	e Harr	is	2. Date of D Month Janua	D	ay Year 27, 2008	3. Time of Death 9:00 A
	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Tov	vn, or Location of Deat	า	4	c. County of Dea	th
			1843 A East Ave.				Dunda1k			Baltimo	ore Co.
_	Funeral		Social Security Number     6. Sex		ast birthday)	If Under 1 Y	ear If Under 24 Hrs. ays Hours Min.	8. Date of Bi	rth	9. Bir	thplace (State or Foreign
Ь	Director		218-05-5278	]M 2□ <b>X</b> F 87	Yrs.	MOTITIS	ays Hours Will.	March			aryland
	D		Usual Residence of Decedent								
	ylan how		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mal a-f sl	io	Maryland Balt	imore			Dunda1k				1 ☐ Yes 2 🔀 No
	r 28,	Director	10e. Street and Number			10f. Zip Co			10g. C	citizen of What Co	ountry?
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show wrt, the Medical Examiner must be notified at	=	1843 A East Aver	nue			212	22	Uni	ited Sta	tes
	ms 2	by Funeral		12. Was Decedent Ever in U.S	S. 13. \	Nas Deceden	t of Hispanic Origin? (S Cuban, Mexican, Puer		0-	14. Race - Ame	
10	r ite	E	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give				to Hican, etc.)		Black, Whit	te, etc.
33	al", o	by	3 ☐ Widowed 4 🏋 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ፟	No Specify:			Specify:	White
21215-0036	2 hor	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	dent's Usual C	occupation		16b.	Kind of Business	/Industry
15	nin 7; n "n Medi	ple	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give life. l	kind of work a DO NOT use r	lone during most of wo etired)	rking			
212	with jiene	E O	8 Years	College (1-401 5+)	HO	memake	r		1	Own Home	2
D	filed Hygi other ent, tl	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle	e, Maide		
Maryland	s 1 and 2 should be file if Health and Mental Hy Item 27 Is marked oth other traumatic event	ToB	Frederick Eckes				Ilrs	ula Kaip	oha s		
7	mari mati	-	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailir	na Address (S	treet and Number or Ri				Zip Code)
Za	d28 thar t7 is		Mrs. Darlene Jacob				leigh Road				
o o	1 an Heal em 2		20a. Method of Disposition	20h PI	ace of Disno	sition (Name	of i	Date		Location - City or	
ō	Pages nent of h int: If Ite		13€ Bunai 2 □ Cremation 3 □ F	Removal from State	emetery, crer	natory or othe	<sup>rplace)</sup> Cemet	-			,
ξį	tmer tant:		4 □ Donation 5 □ Other (Specify)				Jesus 1/	31/2008	j.	Baltimo	ore, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	7			ddress of Facility	1 Home	of D	undalk.	Inc.
	<u> </u>		Duda-Ruck Funeral Home of 7922 Wise Ave. Dundalk, Ma  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ications that caused the death ne cause on each line.	. Do not ent	er the mode o	f dying, such as cardia	or respiratory	arrest,		Approximate Interval Between
8	Physician		Immediate Cause (Final disease or condition	ACUTE	UMM	CART	MAL IN	FARC	TIO	N.	Onset and Death
j	/Medical		resulting in death)	Due to (or as a consequ	ence of):						
	Examiner			ATHERUS	(LER	USIS					307 EARS
	\$ 60	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ence of):						354EARS
1	ansii d	Examiner	Cause (Disease or injury	HYPER	RENS	NGI					3 STEARS
o,	exettin an rial-tr	EX	resulting in death) Last	Due to (or as a consequ	ence of):						
9/	e be rsicie e bui	cal		1.							
68760,	ificat g phy as th	edical									
Box	eath certificate be exected attending physician and for use as the burial-transit	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna	ncy	-				23d. Date of de	elivery
m	d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		∃Ectopic preg≀ ∃Other <i>(</i> s <i>peci</i>				Month	Day Year
P.0.	the cy y the	Physician/N	9 Unknown	9□Unknown		_					
σ.	requires that the death certificate be exected on signed by the attending physician and hould be detached for use as the burial-transit		Part II. Other significant conditions con	ntributing to death but not resu	Iting in the u	nderlying caus	e given in Part I.	23e. Did	tobacco	use contribute t	o the cause of death?
ds	uires sign d be	d by	ATRIAL F	IBRILLAT	NOI			1 🗆	Yes	2 <b>∆0</b> 10 3 □ P	robably 4 Unknown
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3ec	The law rate has be page 2 sh	du						24a. Wa	s an opsy formed?	24b. Were a	utopsy findings available completion of cause of
<u>=</u>	cate pag	Sol						1□ Yes			s 2 □ <b>\</b> \$Ûk
/ite	clan ertifi ector	Be	25. Was case referred to medical examiner?	In a Wall			26. Place of De	ath (Check only	one)		
Division or Vital Records,	Attending Physician: The laver death. Tector: After this certificate has by the funeral director, page 2	2	T Tes 2LX140			nt 3□ DOA		-		6 ☐Other (Spe	ecify)
п	ng P		27. Manner of Death 1 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c.	Injury at Work?	28d. Describe	how in	jury occurred	
<u>Š</u>	Attending r death. ector: After by the funer	atio	2 Accident investigation			М	1 ☐ Yes 2 ☐ No				
<u>×</u>	er de rect	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hor building, etc. (Specify		eet, factory, o	ffice	28f. Location City or To	(Street	and Number or Fl ate)	lural Route Number,
	talors aft	Certification:									
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the 1		29a. Certifier 1 ☐ <b>©ertifying Phy</b>	sician: To the best of my know iner: On the basis of examinat	viedge, deati	h occurred at the	the time, date and place	e, and due to the	e cause	(s) and manner a	es stated.
	the H in 24 <b>he F</b> pfete	Medical	one)	and manner stated.	απον στ πτ			aou at the tille	, udic c	mo piace, and du	to the oddoe(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier			29c. Li	icense number		29d. [	Date signed (Mon	th, Day, Year)
				-	-	D3	33407			January	28, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar DHMH 17 Rev 1/2001

State

Wise Aue. Balto, MO. 21222

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Deepa K Seth, M.D. 207 W

Deepak S 31. Date filed (Month, Day, Year)

JAN 3 1 2008

M.D. 207

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last. Month Hubes 27, January 2008 11:00P<sup>M</sup> enct 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If hat institution, give street and number) Carroll Hospice & Dove House Carroll Westminster If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) March 26,1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours 1□M 2**X** F 214-16-8999 86 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Carrol1 Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 292 Stoner Avenue 21158 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Welsh Elizabeth Mills 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Angela Blevins/GranddaughterPO.38Box Manchester, MD 21102 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Jan. 30. 1 X Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 2008 Brooklyn Park, MD 4 Donation 5 Dother (Specify) 21. Signature of Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Моччії Services 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

**Physician** /Medical Examiner

> the burial-transit and

attending ph for use as the

been signed by the should be detached

s certificate has t irector, page 2 s

this

After

within 24 hours after death

To the Funeral Director:
completely filled in by the

Physician/Medical

Completed by

Be

2

Certification:

Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records,

P.O. Box 68760

**Physician** 

/Medical

Examiner

10a. State

MD

Director

by Funeral

Completed

Be

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**Funeral** 

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Maryland 21215-0036

Baltimore,

Immediate Cause (Final disease or condition resulting in death) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner

ancer. Due to (or as a consequence of): Mahic Due to (or as a consequence of)

Due to (or as a consequence of)

IF FEMALE

23b. Was decedent pregnant in the past 12 months 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death

9∏Unknown

3 □Ectopic pregnancy

5 ☐ Other (specify)

23d. Date of delivery Month Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 □ No

24a. Was an autopsy performed Yes 2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 21410

1 Inpatient 28b. Time of

2 ER/Outpatient 3 DOA 28c. Injury at Work?

26. Place of Death Check onl one

Other: 4 Nursing Home 5 Residence 6 Definer (Specify) DOVE 28d. Describe how injury occurred

Heruse.

27. Manner of Death 1 Natural

5 ☐ Pending investigation 6 ☐ Could not be

determined

28a. Date of Injury (Month, Day Year)

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 ☐ Homicide

1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and ti

-0054218

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Westminster, MD 21157-5629 Raman Kaneria 292 Stoner Avenue

State Registrar

1D

31. Date filed (Month)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Thelma Catherine Helm 26, Jan. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death N/A Genesis Health Care Hamilton Cntr Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 2√F Hours Days MD 01.17.1917 218.07.1492 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits N/A Baltimore MD 1. No 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 U.S.A. 5519 Silverbell Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🖼 No 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) McConell Myrtle Goheggan unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Samuel J. DiBlasi 5519 Silverbell Road, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, MD Chesapeake Crematory 01.29.08 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Cafa/Stephen D. Lohrmann, P.A. 21. Signature of Funeral Service Licensee 8717 Green Pastures Drive, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ALZHEIMER'S 2 No DISFASE 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Wursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At horne, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

/Medical Examiner P.O. Box 68760, Division or Vital Records. death.

physician and s the burial-trans as attending p for use as ed by the a signed by pe has certificate funeral director, this After To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu

**Physician** 

Examiner

**Funeral** 

**Director** 

rai", or items 23a or 28a-f shov Examiner must be notified at

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Medicai

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any injury or c once.

death v

filed within 72 hours after

d 2 should be filed within 7 th and Mental Hygiene. **7 is marked other than "r** 

permit. Pages 1 and 2 Department of Health a Important: if Item 27 is

**Physician** 

Baltimore, Maryland 21215-0036

by Funeral Director

Completed

Be

Examiner

Physician/Medical

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Completed

Be

Certification: To

/Medical

V State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 JAN 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

austahasenes

VERGARA - SOMES

FRANKLIN 9940 Registrar's Signature

29c. License number

D16619

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month CLARA JANUARY 23:30 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL THE JOHNS HOPKINS BALTIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours MARYLAND 215-32-8023 1 M XXX 73 Yrs Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 'natural', or Items 23a or 28a-f show dial Examiner must be notified at MD N/A BALTIMORE CITY 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1604 E. LAFAYETTE AVENUE 21213 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black. White, etc 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No BLACK Specify þ 3 Widowed 4 □ Divorced Specify Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry within 72 permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "na any injury or other traumatic event \*\*\*\* Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY BARTLEY NANNIE CLARK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RONALD JONES / SON 1604 E. LAFAYETTE AVENUE, BALTIMORE, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State METRO CREMATORY 01/30/08 CATONSVILLE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Miter the disclase, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, or heart fairne. List only one cause on each line. 23a. Approximate Interval Between Onset and Death fiate cause (Final se condition in death) **Physician** 1 WEEK SEPSIS /Medical Due to (or as a consequence of) **Examiner** 15 YEARS LIVER PAILURE Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed SO YEARS HEPATITIS and Due to (or as a consequence of) P.O. Box 68760; Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 1□ Yes 2 XNo 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? Hospital or Attending P 24 hours after death. Funeral Director: After t 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Natura! Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier pletely (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 JANUARY 25, 2009 Monumer

Registrar

State

JAN 3

NATALLE MBOWMAN, THE JOHNS HOPKINS HOSPITAL GOO NORTH WOLFESTREET, BALTIMORE, MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyoiene.	Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

**Physician** 

/Medical

Examiner

**Funeral** 

rector

Director

Funeral

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Examiner

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Certification: To

Medical

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31. Date filed (Month, Day,

Year)

2008

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**Physician** /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra attending physician the detached signed by After this certificate Director: within 24 hours a

Division or Vital Records, P.O. Box 68760,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JAN. 29 2008 MARY FRANCES JOHNSON 9:40A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3037 PIEDMONT AVENUE BALTIMORE CITY N/A If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month Day, Year) 5/19/1922 9. Birthplace (State or Foreign S. CAROLINA Social Security Number 6 Sev 7. Age (In yrs. last birthday) Days 1 M 2 T F 85 215-18-9182 Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits XXYes 2 □ No MD N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3037 PIEDMONT AVENUE 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XXNo BLACK Specify. Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES RETAIL 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HENRY MOSES AMELIA JEFFERSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PATRICIA JOHNSON / DAUGHTER 3037 PIEDMONT AVENUE, BALTIMORE, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State MD VETERANS CEMETERY 1 Burial 2 □ Cremation 3 □ Removal from State 02/04/08 CROWNSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE 21. Signature of uneral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD at I inter the discase, or complications that caused the deat ock, or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ause (Final disea r condition resulting in death) Due to (or as a conseq unce of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Donknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 12 No 24a. Was an autopsy 1□ Yes 2☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 8

32. Registrar's Signature

Dad

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month JAN 2<sup>Day</sup> 2008 RAYMOND JOLLEY, JR 11:52 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BETHESDA

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 9, NATIONAL NAVAL MEDICAL CENTER MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Country) Maryland 43 1964 Director 216-78-7551 Usual Residence of Decedent with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits 1 ☐Yes 2 No Directo Virginia Prince William Bristow 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r 9544 Tarvie Circle 20136 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must is onee. United States Funeral Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No1 984

If Yes, Give Year or Dates: 2000 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Medical Technician Prince William County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Jolley, Sr. Frances Flanagan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9544 Tarvie Circle, Bristow, VA 20136 Joann M. Jolley (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 2/6/08 Quantico National 4 Donation 5 Dother (Specify) Triangle, VA 21. Signature of Juneral Service License 22. Name and Address of Facility
A. L. Bennett & Son Funeral Home, Inc. 200 Butternut Dr., Fredericksburg, VA annes 22408 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performet? Yes 217Mo 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Unpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural
2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

- MD

29c. License number

29d. Date signed (Month, Day, Year)

01125/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

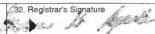
and manner stated

49492-20 (WI) | NATIONAL NAVAL MEDICAL CENTER

SCOTT C. PARRISH LT MC USN BETHESDA MD 20889-5600

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State State Registrar		rtificate of Death	Reg. 1	0000 00110
	Physici	an	Decedent's Name (First, Middle, Last)     Hele	n K•	Jackson		Day Year 3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of Deat		29, 2008   5:29 A Mark 4c. County of Death
	Examin	lei	Jacob's Well Assisted		Bel Air		Harford Co.
6	Funeral Director		5. Social Security Number 218-09-7271 6. Sex 1 □ M 2 ☑ 1	7. Age (In yrs. last birthday)			9. Birthplace (State or Foreign Country)
П	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	ne Maryla 8a-f sho ptifled at	ector	Maryland Harford		Bel Air		1 □ Yes 2 No
	th with the 23a or 2	Funeral Director	10e. Street and Number 403 Cypress Court		10f. Zip Code 21015	_	Citizen of What Country? Jnited States
980	J within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 Yes,	s 21XINo	Was Decedent of Hispanic Origin? (S if Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 Hoo Specify:	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036	hin 72 ho e. an "natui Medical	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking 16b.	Kind of Business/Industry
21		Con	11 Years	Diet	tician		.A. Hospital Center
land	be d d d	To Be	17. Father's Name (First, Middle, Last) Oscar O. Kolstrom		18. Mother's Nat Hilma	ne <i>(First, Middle, Maid</i> Niemi	en Surname)
	2 sh and Is m		19a. Informant's Name/Relationship (Type. Print) Mrs. Jane Jackson-Kols		ng Address (Street and Number or R Cypress Court B		
Baltimore,	e ifer		20a. Method of Disposition  12□ Burial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify)		osition (Name of matory or other place)  n Cemetery 2/1/2		Location - City or Town, State Baltimore, Maryland
Balti	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee		2 Name and Address of Facility al 7922 Wise Ave. D		·
	-		23a. Part1. Enter the disease, of complications the shock, or heart failure. List only one cause of	at caused the death. Do not en			Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		IN INEFECTIVE	J	Onset and Death / min + L
	Examiner			to (or as a consequence or).			
	nsit	Examiner		to (or as a consequence of):			
68760,	ficate be executed physician and streets the burial-transit			to (or as a consequence of):			
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to		inderlying cause given in Part I.	23e. Did tobacc 1 ☐ Yes	o use contribute to the cause of death?  2 □ No 3 ☑ Probably 4 □ Unknown
ecol	e law rec has beel e 2 shou	Completed	MOMIU STENOIT	ſ		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
a E			EDNALIMO			performed 1 Yes 2 ∠	? death? No 1 ☐ Yes 2 ☐ No
Ξ		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1	☐ Inpatient 2 ☐ ER/Outpatien	Other	ath (Check only one)	0 TOther (G(6))
on or	ine ine		27. Manner of Death  Natural 5 □ Pending  (A	ate of Injury 28b. Time of Injury Injury		lome 5 ☐ Residence 28d. Describe how in	
Division or Vital Records,	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 28e. Pt	ace of injury - At home, farm, st uilding, etc. <i>(Specify)</i>		28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	e Hospi 24 hour e Funer, letely fills	ledical (	(Check only 2 Medical Examiner: On the	the best of my knowledge, deat e basis of examination and/or in nanner stated.	th occurred at the time, date and plac nvestigation, in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	~ <i>1</i>	29c. License number	29d. I	Date signed (Month, Day, Year)
	11		30. Name and address of person who completed of	ause of death (Item 232) (Time	D1864~	1	125/09
-	4		I. DAN AMENT,	mis 3218.	13 DAILUDELLM	10 nh.	3 ALT, WD 21237
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registrar's Signature	SALL D		

**Physician** /Medical Examiner A.M. Kechenderfer Nancy 1/37/08 11.41 Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

certificate Certification:

al or Attending Physician: 1 s after death. al Director: After this certificated in by the funeral director, p To the Hospital or within 24 hours aft To the Funeral Di completely filled in

State Registrar

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31. Date filed (Month, Day, Year)

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2008

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Year) (Month, Day Injury 1 X Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifies 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hossein Akhondi M. D. 8600 Old Georgetown Rd. Bethesda, MD 20814

32 Registrar's Signature

D0062167

1/27/08

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 9:00 PM. kinving 7008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner BALTIMOR ANDAIL 5. Social Security Number (In vrs. last birthday) In. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Days 1**⋈**M 2□F Director 214-64-7855 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 22------ any injury or other traumath. 10c. City. Town or Location 10d Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 ☐ No Director MD Baltimore Owings Mills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 106 Enchanted Hill Rd. Apt. 104 21117 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify Specify: African American 3 ☐ Widowed 4 🏋 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer 12TH Corrections Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Lewis King Alice Maria Boston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36 Townhouse Circle Baltimore, MD 21244 Paulette King /Ex-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1♥ Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbutus Mem. Park 2-2-08 Arbutus, MD 22. Name and Address of Facility WylieFuneral Home of Balto. Co. 21. Signature of Funeral Service Licensee 9200 Liberty Rd. Randallstown, MD 21133 NACON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed attending physician Physician/Medical IF FEMALE: ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 □ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□No 1 TYes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA 2 Inpatient this 28a. Date of Injury filled in by the funeral 28b. Time of 27. Manner of Deat 1 Natural 2 Accident 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 Tyes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After

> State Registrar

29d. Date signed (Month, Day, Year)

ess of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Compan 31. Date filed (Month, Day, 2008

29b. Signature and title of certifier

State Registrar TOLL

ERSON.

801

32 Registrar's Signature

House Ave Frederick

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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		For State		State of M	larylar		artment of h			ental Hy	/giene	Э	
		1 - State Registrar  1. Decedent's Name	e (First Middle	l ast)		Ce	rtificate of	Deat		2. Date of De	Reg. No	200	8 021,52
Physicia /Medic			lizabeth		yle							19 . Ye	208 5:45Рм
Examin		4a. Facility Name (In	not institution, o	give street and number	)	nter	4b. City, Town, o	or Locatio	on of Death	on	40	c. County of De	eath altimore
Funeral Director		5. Social Security N 218-14-2		4 🗆 14 . 0 🖂 🗉	ge (In yrs.	last birthday, Yrs.	) If Under 1 Year Months Days	If Und	s Min.	8. Date of Bi (Month, Di June 6	av. Year.	0-	Sirthplace (State or Foreign Country) ary land
put N		Usual Residence of 10a. State	Decedent 10b, County		10c Cit	v. Town or L	ocation				,		10d. Inside City Limits
Maryla f shor	tor	Md.	Baltimo	re		hervi							1 Tyes 2 No
with the la or 28a	Director	10e. Street and Nur 810 Br	mber anford (	Circle			10f. Zip Code	093			10g. Ci	tizen of What (	Country?
death ms 23	Funeral	11. Marital Status		12. Was Deceden	Ever in U	.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic (	Origin? (Spec	cify Yes or No	0-	14. Race - Ar	nerican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important; If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	1 ☐ Never Marri 3 ☐ Widowed	ied 2□ Married 4□Divorced	Armed Forces 1	No		1 ☐ Yes 2 ☑ No	an, Mexi Speci		Rican, etc.)		Black, Wi	
72 ho "natur dical	eted	(Spec	15. Decedent's	Education grade completed)		16a. Dece	edent's Usual Occup e kind of work done DO NOT use retire	oation during m	nost of workin	g	16b. K	(ind of Busines	ss/Industry
within iene. than	Completed	Elementary/Seco	ndary (0-12) 12	College (1-4or	5+)	1	maker	a)				Own Hom	e
e filed al Hyg I other vent, i	Be C	17. Father's Name (	First, Middle, La	st)				18. Mo	ther's Name	(First, Middle	e, Maider	n Surname)	
ould b Ment narked	ם		Ervin L					<u> </u>			gers		
and 2 sh ealth and n 27 Is m er traum		Ms. Jean		ey/ Daughte	er		ing Address <i>(Street</i> 15 Warm G						
ges 1 If item or oth		20a. Method of Disp 1 X Burial 2 [		☐Removal from State	, (	cemetery, cre	osition (Name of ematory or other pla			ate		ocation - City	
artmen artmen ortant; injury		4 ☐ Donation  21. Signature of F	5 Other (Spe		Du'	•	Valley Me		2-1-0			nonium,	Md.
Deperment of the second of the		b //		5			2. Name and Addre Ruck To 1050 Yo	wson	Funer	al Hom	ne, l	Inc. 21204	
粉		23a. Part1. Inter the shock, or hea	ne disease, or co	emplications that cause ly one cause on each	d the deat	h. Lo not en						.1204	Approximate Interval Between
Physician		Immediate Cause ( disease or condition resulting in death)	Final	_a. PNEU									Onset and Death
/Medical Examiner		resulting in death)	4	Due to (or a	s a conseq	uence of):							
	Jer	Sequentially list cor if any, leading to im cause. Enter Unde cause (Disease un	nditions, imediate	b Due to (or as	s a conseq	uence of):							
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be exe		resulting in death) L	.431	Due to (or as	s a conseq	uence of):							
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 □ 9 □ Unknown	months?	23c. if yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у				23d. Date of o Month	delivery Day Year
ires that the de signed by the a l be detached i	by Ph	_		contributing to death	but not res	ufting in the u	ınderlying cause giv	en in Pai	rt I.	23e. Did	tobacco	use contribute	to the cause of death?
w require	ed b	DILATED	CARDIOM	IYOPATHY						10	Yes 2	100 3□	Probably 4 ☐Unknown
slcian: The law r certificate has be irector, page 2 sh	Completed									24a. Was auto perfe	an psy ormed? 2 No	prior t	
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To the within To the comp	M	29b. Signature and	title of certifier	Helou,	n.]	١.	29c. Licens	e numbe			//	_	nth, Day, Year) 29, 2008
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Physicia /Medic		Charles	R.	Laire						S WIN	ny 29	7608	A 13 pm	
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Funeral		Union Memo  5. Social Security Number		. Hospita 6. Sex	7. Age (In yrs.	last birthday)	Baltim If Under 1 Year	ore If Under	24 Hrs.	8. Date of Bi	th	n/a	hplace (State or Foreign	
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after death with the Manylar or items 23a or 28a-f show miner must be notified at	Director	MD	N/	A	B	altimor					10 0'''		1 X Yes 2 □ No	
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Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certifica itely filled in by the funeral director, is	Certification:	3 ☐ Suicide 6   4 ☐ Homicide	□ Could n determi	nod   28e. Pia	ce of injury - At he Iding, etc. (Special		eet, factory, office			28f. Location ( City or To	Street and Nui wn, State)	mber or Ri	ural Route Number,	
To the Hospital or Attending R within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical C	29a. Certifier (Check only one)	Certifyin Medical	Examiner: On the	he best of my kno basis of examina anner stated.	owledge, death ation and/or inv	occurred at the tile restigation, in my o	me, date a opinion, de	nd place, ath occur	and due to the red at the time	cause(s) and , date and place	manner as	s stated. e to the cause(s)	
To the within 2. To the complet	Me	29b. Signature and title	of cortilier				29c. Licens	e number			29d. Date sig	ned (Mont	'h, Day, Year)	
		1		700	.6.		10	1491	14		JANY	44 c	37, 2008	
8		30. Name and dress of	of person	who completed ca	use of death (Iter	n 23a) (Type, F	Print)	60	1.	117	n= 12	1000	27, 2008 0 4021212	
Stat	te	31. Date filed (Month, D	ay, Year)		Registrar's Signa	ature	Part of	1	10-	1 0	י עוד א	401	O PRAIRIE	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year  $P^{M}$ January 25, 2008 1:20 Willis Leach 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 3, 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 80 234-40-2838 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20895 3908 Spruell Court U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ﷺ 124 Yes 2 ☐ No4 / 2 / 46 If Yes, Give Year or Dates: 1 / 28 / 48 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry NSA Elementary/Secondary (0-12) College (1-4or 5+) Mathematician Federal Government 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilbur Leach Annie Calhoun 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Violet Leach (Wife) 3908 Spruell Ct., Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State Old Pine Cemetery 1/29/08 Purgitsville, WV 4 ☐ Onation 5 ☐ Other (Specify) <sup>22</sup>. Name and Address of Facility Fraley Funeral Home, Inc. 145 N. Main St., Moorefiels, 21. Signature of Funeral Service Lice Lee WV 26836 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Arrythmia Due to (or as a consequence of) Respiratory Failure Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Advanced Chronic Obstructive Pulmonary Disease Severe Pulmonary Hypertension 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Cardiomyopathy 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Chronic Liver Disease 24a. Was an autopsy performed? 1∐ Yes 2 No Myelodyspllastic Syndrome 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

**Physician** /Medical Examiner death certificate be executed

**Physician** 

/Medical

Examiner

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Completed

Be

**Funeral** 

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Division or Vital Records,

or Attending

Hospital

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Examine burial-transit physician as the burial Physician/Medical as for use ed by the a signed k þ cate has been sig page 2 should b Completed certificate has director, Be 2 this funeral ( After t

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

6 Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of 5 ☐ Pending investigation

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 X Natural

2 Accident

3 ☐ Suicide

4 Homicide

1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

 $M \cdot D$ 

D0064478

29d. Date signed (Month, Day, Year) January 25, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fisehatsion Mehari, M.D31. Date filed (Month, Day, Year)

9901 Medical Center Dr., Rockville,

State Registrar

Certification:

Medical

3 JAN





### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Maria Isabel 10:40 AM ree January 29 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore 104 Carver Road If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 □ M 2 K F 67 Yrs 220-36-8582 3-22-1940 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside Cify Limits 1 ☐ Yes 2 No Baltimore Director WD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 Carver Road 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Food UNKnown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SiDallas St. Baltimore, MD 21222 Janice Lee/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 1-29-2008 Hanover, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Aldress of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee me 1358 7522 Connelley Dr. SuiteP Hangver, MD21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Chronic obstructive pulmonary disease years disease or condition resulting in death) Due to (or as a consequence of): angustive buart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due for as a consequence of). Examiner lobaces abits Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation

Box 68760 P.0. **Funeral** 

Director

28a-f show

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permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must I

Physician

/Medical

Examiner

and

attending physician and for use as the burial-transit

been signed by the should be detached

page

filled in by the

Medical

certificate funeral director,

After this

death.

To the Hospital or Attenct within 24 hours after death To the Funeral Director:

Saltimore, Maryland 21215-0036

be notified

Division or Vital Records.

State

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year JAN 3 1

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certific

EAH WOKFE, MD

6 ☐ Could not be

determined

4940 EASTERN AE. BALTIMORE, MD 21224

\*\*Registrar's Signature Registrar's Signature

MO.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0057577

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1-29-2008

29d. Date signed (Month, Day, Year)

Amend 16a-b, perFH, 876, 2/19/08 TT Department of Health and Mental Hygiene 1- State Registrar Amend 20b, perFHg875, 1/31/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 27 **Physician** 8:30p.M 01 2008 McCallum Lawrence /Medical Jr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Aberdeen <u>llO Kretlow Drive</u> If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**√** M 2□ F Months Days 61 Director 01 26 212-46**-**1264 NC Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 ☐ Yes 🏚 ☐ No Directo MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ral", or items 23a Examiner must b 21001 110 Kretlow Drive U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Aes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black "naturai" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry The Army Thitting & Turner 15. Decedent's Education (Specify only highest grade completed) Whitting Corps of Engineers Elementary/Secondary (0-12) College (1-4or 5+) Transportation Clerk 12th grade Construction Worker **Construction** event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Pages 1 and 2 should be fill timent of Health and Mental H tant: If Item 27 is marked oth jury or other traumatic even Be Lawrence McCallum Sr. Rosie Shipman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lou McCallum-Sister 110 Kretlow Drive, Aberdeen, Md 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2/8/2008 important: If it any injury or c 1🌠 Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Vet 2/6/08 Owings Mills, Md 4 Donation 5 ☐ Other (Specify) 21. Sign tun of Funeral Service Licensee March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** gastric disease or condition resulting in death) /Medical o (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 3 No the Hospital or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 10 10 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Funeral Directory 1 Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical To the Hosp within 24 ho To the Fund completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0063083 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 N. Green St. Baltimore MD 21201 N HORIBA MARGUT 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ð 200 X Ethel Caletha McFadden /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Good Samaritan Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday, **Funeral** Months Days Hours Min 1□M 2□F Director 77 03 165-30-3823 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 1 X Yes 2 □ No Director MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 U.S.A. Funeral 3617 Haywood Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Black 1 ☐ Yes 2 ☐ No Specify: <u>ک</u> 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12th grade College (1-4or 5+) Nursing Assist Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Session Isaac R. Floyd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3617 Haywood Ave, Baltimore, Md 21215 Deborah McFadden-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 2/4/08 Randallstown, Md ☐ Qonation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, 21215 Part1. Enter the disease, or complications that course ck, or hear billure. List only one cause on ea Approximate Interval Between Onset and Death mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2□No 24a. Was an autopsy performed? Yes 22 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes VI No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760, ed by the a detached f been signed by should be detact has After

filled in by the within 24 hours after death To the Funeral Director; Medical

"natural", or items 23a or 28a-f show edical Examiner must be notifled at

and 2 should be filed withi ealth and Mental Hygiene.

Maryland

Baltimore,

Is marked other

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ev

State

(Check only one)

29b. Signature and title of certifier

Date filed (Month, Day, Year)

JAN 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

March Sent

Registrar

DHMH 17 Rev 1/2001

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

eet Baltinione, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 02458 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January Physician Karen Elizabeth Metzger 21, 6:15 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number)
Gilchrist Hospice Center 4b. City, Town, or Location of Death Towson 4c. County of Death **Examiner** Baltimore Months Days Hours Min. Aug. 22, 1947 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 TF 60 Maryland 217-50-1994 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County Baltimore MD 1 XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code be or 21218 708 E. 37th St. United States ral", or Items 23a Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑
If Yes, Give
Year or Dates: 2 No White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 2 Specify: 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5± Elementary/Secondary (0-12) Medical Recorder Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Metzger, Jr. Elizabeth Poos ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2497 Amber Orchard Ct. #102, Odenton, MD Leslie Metzger / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 01/24/08 Beltsville, MD 5 ☐ Other (Specify) 4 □ Donation 21. Signature of Funeral Service Loanspe Moc CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 NO0382 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician concer of cast disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 18 months? Day 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy perform certificate To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) WOSPW 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 1 Natural 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

5 State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year) Binuary 22 2008

JONSIN MO 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5:45P M Mosetti 7003 29 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carle way Gerrins Baltonine Yanku. 14 If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 18 M 2□ F Yrs. 218.60.4869 56 12.17.1951 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County Ocean City 1 Nes 2 No MD Worcester Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21842 U.S.A. 17 43rd. Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospitality Chef 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elaine Gorschboth Joseph Mosetti 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anthony Mosetti/Brother 17 Paula Place Apt. 3A, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any Injury or o 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 01.30.08 Beltsville, MD Chesapeke Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Cafa/Stephen D. Lohrmann P.A. 21. Signature of Funeral Service Licensee 8717 Green Pastures Drive, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bladder Cencer **Physician** metastic iscars disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-tran physician and Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the at d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed Anemai 24a Was an 24b. Were autopsy findings available page 2 Certification: To 2

Division or Vital Records, P.O. Box 68760, After this certificate or Attending Physician: after death.

| Director: After this certification of the funeral director, completely filled in by

Y TIOPING		autopsy performed? prior to completion of cause of death?  1 □ Yes 2 ☑ No 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death (	Check only one)
examiner? 1 □ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	e 5 ☐ Residence 6 ☐ Other (Specify)
7. Manner of Death 1 ∰natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year) Injury Work?	d. Describe how injury occurred
3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying P	nysician: To the best of my knowledge, death occurred at the time, date and place, an	

(Check only 2 Medical Examiner		curred at the time, date and place, and due to the gation, in my opinion, death occurred at the time.	
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Yea
hung Kley	MO	P31295	1/29/08

	_	(1)	/-	()				
30.	Name and addre	ess of	person who	completed	cause of de	eath (Item 2	За) (Туре	, Print)
	wende		Woesz	67	01 ~	Char	45	SL

21204 70Ws~ 6701 H Charles St Suite 4202

State Registrar

Medical

Klors2 31. Date filed (Month, Day, Year) SUUS

within 24 hours a To the Funeral I Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 26 11:00 PM Henry Michael McGuire /Medical 4a. Facility Name (If not institution, give street and number). 4c. County of Death Examiner 4b. City. Town, or Location of Death da ank Ball Timore If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
VA 5. Social Security Number 8. Date of Birth (Month, Day, Year) 05.24.1954 7 Age (In yrs. last birthday **Funeral** Days 1 M 2 □ F 53 212.62.7722 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at Director Baltimore 1 ☐ Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21220 7409 Greenbank Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Excavating permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Ewing <u> Henry David McGuire</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antoinetta McGuire/Wife 7409 Greenbank Road, Baltimore, MD 21220 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 remation 3 ☐ Removal from State Chesapeake Crematory: 01.31.08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann P.A. 21. Signature of Funeral Service Licenses 8717 Green Pastures Drive, Baltimore, MD 21286 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due lo (or as a consequence of): Examiner Se mentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 1 No 1 Tes 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed. 1☐ Yes 2☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 Vital filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 0 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Hospital 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10063327 Jan. 26, 2008 phizawit-Wordenut 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimure, MD 21237 9000 Frank In Square Drive GIZAW WOLDEHIWOT, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 3 1 Registrar

DHMH 17 Rev 1/2001

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ENDA Year JAN 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A **Baltimore** 709 Nottingham Road - 5B If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 ☑ F Days Director Maryland 45 Apr 25, 1962 212-96-7418 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits rral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Directo **Baltimore** Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 709 Nottingham Road #5b 21229 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or itea ury or other traumatic event, the Medical Examines 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Completed by Specify Specify. Black 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Schools Teacher Para Professional 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Laura D. White Benjamin Vaughn P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 709 Nottingham Road - 5B Baltimore, Maryland 21229 Tiesha Maynor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Windsor Mill, Md. 01/31/08 4 □ Donation 5 □ Other (Specify) King Memorial Park 21. Si f Funeral Syrvice Lio 22. Name and Address of Facility ature Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** noun 10 /Medical to (or as a consequence of): Examiner omarmons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due of (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): physician a Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 1 Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month 4☐Pregnant at time of death 5 Other (specify) by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No has been signed to 2 should be 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate ha 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner' Other: 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 2 Accident 5 Pending investigation (Month, Day Year) Injury a er death. I Director: A d in by the fu 1 ☐ Yes 2 □ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I completely filled 1 Certifying Physician: To the best of ..., 2 Medical Examiner: On the basis of examiner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, 29a. Certifier Medical (Check only mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

Registrar

one) 29b. Sig/13

31. Date filed (Month, Day,

2008

January

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Physician /Medical Examiner **Funeral** Director r 28a-f show notified at

Ruth

"natural", or items 23a or idical Examiner must be r Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natu any injury or other traumatic event, the Medical

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed completely filled in by the funeral director, within 24 hours after death.

To the Funeral Director:

4a. Facility Name (If not institution	, give street and number)	4b. City, Town, o	r Location of Dea	th	4c. Count	4c. County of Death			
Washington Ad	Takoma	Takoma Park			Montgomery				
5. Social Security Number		e (In yrs. last birthday 79 Yrs.	(In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month			f Birth 9. Birthplace (State or Foreign			
578-40-7921	578–40–7921 1□M 2X 7			Tiodis Willi	June 2	5,1928	Washington DC		
Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or L	ocation				10d. Inside City Limits		
	. 1. 4	Washingto		The same of the sa					
District of Col	umbia								
10e. Street and Number 1519 Isherwood	Ctroot N F		10f. Zip Code				g. Citizen of What Country? [ <b>Inited States</b>		
		- 1 110 Tab							
11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> </ol>				<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>		
1 ☐ Never Married  Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 Tes 2 If Yes, Give Year or Dates:	40	1 ☐ Yes 2 🙀 No Specify:				ify: Black		
					Decedent's Usual Occupation 1				
(Specify only highes	st grade completed)	(Give	(Give kind of work done during most of working				Business/Industry  Marriott		
Elementary/Secondary (0-12) <b>Twe1th</b>	College (1-4or 5	p+}					t Shoppe		
17. Father's Name (First, Middle,				18. Mother's Na	me (First, Middle,				
Edwin M. Bowie				Martha	Baddy				
19a. Informant's Name/Relations	nip (Type. Print)	19b. Mail	ing Address (Street	and Number or Fi	ural Route Numb	er, City or Towi	n, State, Zip Code)		
John Moss/Husba	nd	1519	Isherwoo	d St NE	Washingt	on DC 2	20002		
20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other pla	na) Tame	Date 20	20c. Location	- City or Town, State		
Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			t Cemeter		ury 29,	Washington DC			
21. Signature of Funeral Service							son Funeral Home Inc		
1 Chiefel	1/1/2						DC 20020		
23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused						Approximate		
shock, or heart failure. List Immediate Cause (Final	only one cause on each li	ank			Interval Between Onset and Death				
disease or condition resulting in death)	a. Duo to (Fran	a consequence of);	OCK				ivee RD		
	So So	O TP C D in	nia				Wealla		
Sequentially list conditions,	b. Diaeta (or as	a onusedness of,	1100			0000100			
cause. Enter Underlying Cause (Disease or injury	Pro	uman	10		410011				
that initiated events resulting in death) Last	Due to (or as	a consequence of):	· CC	2			weeks Weeks Years		
	Chron	vic Re	nal Fo	ailure	2		Years		
		, , , , , , ,					10015		
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregnancy				23d. D	Date of delivery  Month Day Year		
in the past 12 months?	1 Live birth 4 □ Pregnant a		□Ectopic pregnanc □ Other <i>(specify)</i> _	у					
1 ☐ Yes 2★ No 9 ☐ Unknown	9□Unknown								
Part II. Other significant condition	II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute								
					1 🗆 '	Yes 2 No	3 ☐ Probably 4 ☐ Unknown		
					24a. Was	an 24h	. Were autopsy findings available		
	psy ormed?	prior to completion of cause of							
25. Was case referred to medical	1 Yes 2)								
examiner?	Hospital:	ent 2 ☐ ER/Outpatie	26. Place of Death (Check only one)  11 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death	28a. Date of Inju	ry 28b. Time	of 28c, Inju	rv at	28d. Describe				
1 Natural 5 ☐ Pending 2 ☐ Accident investig	g (Month, Daj	y Year) Injury	M 1	rƙ?  Yes 2 ⊟ No	, , , , , , , , , , , , , , , , , , ,				
3 ☐ Suicide 6 ☐ Could r	Street and Nun	reet and Number or Rural Route Number,							
4 Homicide building, etc. (Specify)  City or Town, State)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state									
29b. Signature and title of certifier	ned (Month, Day, Year)								
1 Mkari	MH		D1	8895		Vinuari	y 23, 2008		
30. Name and address of person	who completed cause of d	eath (Item 23a) /Typo	Print)	- 0 / -	L	25,75007	, - ,		
Mohare & I	A COMPleted cause of a	7/2 // // //	wroll K	TO C+	0 2Un 7	Takam	y 23, 2008 a Park, MO 20912		
31 Date filed (Month, Day, Year)	32. Registr	ar's Signature	TUIL T	10E 1214	370 /	MAOM	4 IWINJIND WILL		

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 19a-b, perFH.g875, 1/31/08 TCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marian K. Nelson January 27, 2008 5:15 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Care Nursing and Rehab Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 206-42-5699 1 ☐ M 2 👿 F 85 10/8/1922 Yrs. PA Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at MD Towson Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7001 North Charles Street 21204 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill iment of Health and Mental Hiant: If item 27 is marked oth Be James G. Kerr Elizabeth Clark 19 Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; if item 27 is any Injury or other trai once. Steven Nelson / Son Jamiseson Road, Lutherville, MD 21093 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Deurial 2 □ Cremation 3 Removal from State Arlington Cemetery 02/01/2008 Drexter Hill, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuqeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DEMENTIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Entire design of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate has 1□ Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Hospital or Attending 1. Natural 1 ☐ Yes 2 ☐ No 124 hours after death.

Ie Funeral Director: A pletely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) PS7722 M-D JANUARY 29 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pikesville 10 TREE ROAD # 300 LEDNARD RICH ARDSON M.P 1838 GREENE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar DHMH 17 Rev 1/2001 JAN 3

		-	For State Registrar	State of Ma		epartment of F Certificate of				8 02461
			Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath	3. Time of Death
٠	Physicia /Medic		MARGIE		NER	<u> </u>		JANUARY	29, 2008	
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of De	ath
7	1. 10. 278 2. 10. 278			E NIA	1		NIA		BACTI	
	Funeral		5. Social Security Number 6. Se	ex 7.Age □M 2/21F	(In yrs. last birtho	Months   Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	(, Year) (	irthplace (State or Foreign Country)
ŀ	Director	ŀ	Usual Residence of Decedent		90	3.		Oct. 2.	5,1917	5.0.
	/land ow at	_	10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	Mary t-f sh filed	ţċ	Md. BA	TIMORE	/	VIA				1 □Yes 2X No
	th the	Director	10e. Street and Number			10f. Zip Code		-	10g. Citizen of What	Country?
	death with the Maryland ms 23a or 28a-f show rmust be notified at	a le	4276 MARY	KING	E TR.	21.	133		4.5.	A.
	r dea	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	<ol> <li>Was Decedent of F If Yes, specify Cub</li> </ol>	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wi	nerican Indian, nite, etc.
30	hours after tural", or Ite al Examine	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X N If Yes, Give Year or Dates:	lo	1 □ Yes 2 No	Specify:		Specify:	2/21
-0036	be filed within 72 hours after death with the Marylar ital Hygiene. Ital Hygiene. Ital well an "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	90	15. Decedent's Ed		16a. D	ecedent's Usual Occup	oation		16b. Kind of Busines	s/Industry
5	in 72 n "na Aedic	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5	(6	Give kind of work done fe. DO NOT use retire	during most of work	king		
7 7	s within giene.	E O	Elementary/Secondary (0-12)	N/A	+)	DOMESTIC	· Work	ER	FRZUM	E Home
פ	e file al Hy othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Surname)	
<u>a</u>		2	SAM K.	ELLY			BESSI	E.	SMALL	
<u>a</u>	2 sho and is ma		19a. Informant's Name/Relationship (7	ype. Print)	19b. N	lailing Address (Street	and Number or Rui	ral Route Numbe	er, City or Town, State	, Zip Code)
%	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		ESTELLE MC PANTE	LS / drava.	MER 43	isposition (Name of	KIDGE	Date KAN	20c. Location - City	1.01.01.00
	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		cemetery,	crematory or other pla	ce) 2/	z ino	2. Take Change	or Town, State
	C @ -		4 Donation 5 □ Other (Specify		INEETEN/	22, Name and Addre	Come!	708	WINGERED	5.6.
Balti	permit. Pa Departmer Important: any Injury once,		21. Signature of Funeral Service Licen	1 Freday	tu	2700 En	mounso.	Ave-	Galto: MA	1.21223
١			23a. Part . Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each lin	the death. Do no	t enter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	2		VD				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of)	:				
	Lxaiiiiiei	_	Sequentially list conditions,	b. Due to for an	a consequence of)					
	ted rsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence or,					
	ificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of)	:				
09/89	e be (	edical	(	d						
ğ	± D 66									
X Q Q	death certifi e attending d for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	pf pregnancy 2 □ Fetal death	3 □Ectopic pregnanc	v		23d. Date of o	
Э П	e dea the att	Physician/M	in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□Unknown	time of death	5 ☐ Other (specify) _			Month	Day Year
7.	w requires that the de been signed by the should be detached	Phy	Part II. Other significant conditions of	ontributing to death b	ut not resulting in t	ne underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ds,	signe signe d be o	d by		3	3	, 5		1 🗆 Y	/es 2□No 3□	Probably 4 Dunknown
Vital Record	v requ	Completed						24a. Was a	an 24h Were	autopsy findings available
Ğ T	ilclan: The law certificate has b ector, page 2 sh	mp						autop	rmed? prior t	o completion of cause of
<u>n</u>	in: T		25. Was case referred to medical				26. Place of Dea		2 <b>1</b>	es 2 Mo
	ysiclan: iis certific director,	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outp	atient 3 DOA Oti	201		dence 6 □Other (S	pecify)
0	Attending Physician: r death. ector: After this certific by the funeral director,	T:U	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day			ry at rk?	28d. Describe h	now injury occurred	
0	tendir leath. tor: Af the fur	atio	2 ☐ Accident investigation			M 1	]Yes 2 □No			
UIVISION	or Att ter de lirect	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc	ury - At home, farm c. (Specify)	n, street, factory, office		28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,
	pital ours at eral C		29a. Certifier 1 Certifying Ph	vsician: To the hest	of my knowledge	death occurred at the t	ime date and place	and due to the	cause(s) and manner	ae etatod
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical			f examination and/ ated.	or investigation, in my	opinion, death occu	rred at the time,	date and place, and o	lue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	^	1	29c. Licens	se number	7	29d. Date signed (Mo	onth, Day, Year)
			· · · . /	Chu	Kls		5155	5	MNYKMY	20,008
	6		30. Name and address of person who	completed cause of d	eath (Item 23a) (T	ype, Print) JHC, (	SALT	0. M.	0 211	as stated. Jule to the cause(s)  onth, Day, Year)  30, 2008
	Sta Registr		31. Date filed (Month, Day, Year) 20	08 Registra	ar's Signature	and I				
				J						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygicne Certificate of Death Reg. No. ent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** /Medical (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner onualesce Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day Social Security Number 6. Sex **Funeral** Days Months Hours 1₺M 2□ F and Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Depentment of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Evarinal must be notified at 10d. Inside City Limits 10a / State County 10c. City, Town or Locetion 1 ☐ Yes 2 ☐ No Funeral Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Numb 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 2 N6 1 ☐ Never Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0020 Specify: β 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary Secondary (0-12) College (1-4or 5+) a Dores 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle. Be ship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, cremately oriother 20c. Location - City or Town, State Method of Disposition Date y, cremately or other place) 1 Burial 2 □ Cremation 3 Removal from State 0 emeter 4 Donation 5 Other (Specify) 22. Name and Address of Facility 0 Services 21. Signature of Funeral Service Licenses DIE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. etim OSR Approximate Interval Between Onset and Death the mode of dying, such as cardiac or respiratory arrest, **Physician** idiac Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and I for use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) been signed by the a should be detached f 23b. Did tobacco use contribute to the ceuse of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tonknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 s hes 1 ☐ Yes 21□No 1 ☐ Yes 2 ☐ No After this certificate the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: A Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 ☐ Pending investigation ar death. 1 Yes 2 🗆 No 2 Accident Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide within 24 hours e To the Funeral D Hospitai cai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 2 29d. Date signed (Month, Day, Year)

State

of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WID

29b. Signature and title

Aditua Chopra

31. Date filed (Month, Day, Year)



29c. License number

D57028

#231

Annapolis

- 30-08

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	For State Registrar	State of Ma	arylan		artment of H			giene Reg. No. 200	08 02466	
10			1. Decedent's Name (First, Middle, La	ast)					2. Date of Dea		3. Time of Death	
B	Physici /Medi		Baby Girl Out	law					Januar		008 5.13 PM	
Examiner  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Lo							Location of Death	1.	4c. County of	Death		
(a) (g)			The Johns Ha	okins Ho	Spite	al	Battin	rore C'17	4			
	Funeral			Sex 7.Ag 1□M 21∑1F	e (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	Date of Birt (Month, Day	y, Year)	Birthplace (State or Foreign Country)	
- 50	Director		none Usual Residence of Decedent	-X		115.	10		Jan 10	, 2008 N	Maryland	
	and w t		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits	
	Maryl f sho	ō	MD		Ba1	timore					1√2 Yes 2 □ No	
	the 28a- notif	rec	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	at Country?	
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Ö	3725 Oakmount Ave	20116				21215		USA		
	ms 2	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.	S. 13. \	Mas Decedent of Hi f Yes, specify Cuba		pecify Yes or No-		American Indian,	
9	after or Ite nine		1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔯 I If Yes, Give	No		r Yes, specify Cuba 1 □ Yes 2 🔯 No		э нісап, етс.)		White, etc.	
03	ours ral",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			ILL Tes ZMINO	Specify:		Specify:	black	
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anc	d be f intal l ed of	Be c	Tr. Fadio S Hamo (Froi, Middle, Eas.	4			unk		a Outlar	· ·		
Maryland	should ind Men marker umatic	ပ	19a. Informant's Name/Relationship	(Type Print)		19h Mailir	g Address (Street a	<u> </u>			tate Zin Code)	
Z	id 2 s lith an 17 is trau		The Johns Hopkin				N. Wolfe			-	287	
ē,	thealth tem 27 other to		20a. Method of Disposition	Впобрабия	20b. P	lace of Dispo	sition (Name of	i	Date	20c. Location - Ci	ity or Town, State	
JO T	Pages Tent of I int: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 【Al Other (Speci		1	ететегу, сгег	natory or other plac	:e)				
Baltimore,	nit. Fartmoortar		21. Signature of Funeral Service Lice Ronald S			. 2	. Name and Addres	Soft Facility Car	-d 655 W	Baltimo	ore Street	
ñ	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		Ronald S.	wade, Dir	ector	_	altimore			· Darerin	310 511000	
			a. Part1. In ter the disease, ir conshock, on peart failure. List only	plications that caused	the death				THE STATE OF THE S	rest,	Approximate Interval Between	
. 18	Physician		Immediate Caus III nal disease or condition	a DOW	4 1	1 /	ration				Onset and Death	
	/Medical Examiner		resulting in death)	a. Due to (or as			Cessol III				4710010	
			Coquentially list conditions	. Nec	rofi	zina	Enter	o codifie			8 hours	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence 🔱						
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and oage 2 should be detached for use as the burial-transit		resulting in death, East	Due to (or as	a consequ	uence ot):						
87	cate b	Physician/Medical	•	d								
9 ×	death certifica attending ph	/Me	IF FEMALE:	23c. If yes, outcome	nf pregna	ncv				004 0-4-	- f - d - P	
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	Ideath 3□	Ectopic pregnancy Other (specify)	,		23d. Date		
P.0.	the d	ıysi	1 □ Yes 2 □ No 9 □ Unknown	9□Unknown	time or de	outil or	Journal (apodity)					
	that ned b	7	Part II, Other significant conditions	contributing to death b	ut not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contrib	ute to the cause of death?	
Vital Records,	v requires that the d been signed by the should be detached	d by	rrematurit	4					1 🗆 1	res 2 No 3	☐ Probably 4 ☐ Unknown	
Ö	w requir s been si should	Completed		1					24a. Was		ere autopsy findings available	
Re	The lav	mc d								rmed? dea	or to completion of cause of ath?	
a		Be C	25. Was case referred to medical		· · · · · · · · · · · · · · · · · · ·			26. Place of Dea	1 XYes		Yes 2□No	
>	ysici is cer direct	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatie	ent 2 🗍	ER/Outpatien	t 3 DOA Othe	er.			(Specify)	
1 O.	ding Physician; n. After this certific funeral director,		27. Manner of Death	28a. Date of Inju (Month, Da	iry	28b. Time of	28c. Injur		4 Nursing Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred			
0	To the Hospital or Attending Physician: Within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	atio	1 Natural 5 Pending investigatio	n	, , , , ,	,,		Yes 2□No				
Division	ir Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location City or T						28f. Location (S City or Tox	(Street and Number or Rural Route Number, own, State)		
	ital or risalitation risalitati											
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis o	f examinat	wledge, death tion and/or in	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and manr date and place, an	ner as stated. Indidue to the cause(s)	
	thin 2	Med	29b. Signature and title of certified	and manner sta	ated.		29c. License	e number		29d. Date signed (	(Month. Dav. Year)	
	⊢≯⊬ŏ		Mel in his	2/20					9	Tanian	171 7000	
			30. Name and address of person who	completed cause of d	eath (Item	(23a) (Type		6465		Jurium	14,000	
			Kurlen Payton	n 600 N	orth	Wolfe	Shr	Baltin	lore, M	aryland	21287	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ture	alles		1			
	Regist	rar	JAN 3 1 20	NO PER ING	THE PARTY OF THE P	Sept.	- April -					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 7:43 AM M 21, 2008 Joseph Owsik January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Mar 14, 1936 Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F Director 71 Maryland 219-32-1975 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director MD Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1129 A Clayton Road 21085 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 ☑ No Specify: white Specify þ 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 engineer ould be filed w self employed and Mental Hygin is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic everes. Joseph Owsik Rose Eaves 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Carter/daughter 2626 rocks Road Forest Hill, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☑ Other (Specify) 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate sause (Final disease or condition resulting in death) State Anatomy Board 655 W. Baltimore Street Approximate
Interval Between
Onset and Death
2 9 9 5 **Physician** /Medical Examiner Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examiner and Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9□Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown momen Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Vascu de 24a. Was an performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 □ DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident n by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical

Besth. 13AM

21215-0036

Maryland

Baltimore,

with the Maryland

State

29b. Signature and title of certifier

Mchandu,

NNENNA UCHENDU

31. Date filed (Month, Day, Year) JAN 3 1 2008

Registrar

DHMH 17 Rev 1/2001

500 UPPER CHESAPEAKE OR BELAIR, MD

29c. License number

D0066136

29d. Date şigned (Month, Day, Year)

2008

21014.

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NNENNA UCHENOU 2 MD.

32. Registrar's Signature

HOSPITALIST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Roger D. Redden 3:31 PM January /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A 8. Date of Birth Dec. 19, 1932 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1**X** M 2□ F 75 WashingtonDC Director 220-28-1758 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or Items 23a or 28a-f show dical Examiner must be notified at N/A 1 Yes 2 No Director Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Roland Mews 21210 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Lawyer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jones Redden Lavman Elizabeth Roger Duffev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Roland Mews Baltimore, Md. 21210 Mrs. Gretchen S. Redden/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Co. 1-30-08 4 ☐ Donation 5 ☐ Other (Specify) Towson, Md. 22. Name and Address of Facility 21. Signature of Funeral Servi e Licensee Ruck Towson Funeral H 1050 York Rd. Towson, 23a. Part1. Enter the diseas a or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or conditior resulting in death) Brain Stem haemorrhage /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Par Uinson
Due to (or as a consequence of): Examiner sician and burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🗙 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28d. Describe how injury occurred 1 XNatural 5 ☐ Pending investigation

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

2 Accident

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier Elie Alcheivih

6 ☐ Could not be

determined

Al 2438946

29 Scos.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

MD Alcheirin 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Colette Edith Rancourt PM 17 2008 /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shadyside Columbia Beach Road Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Mithigan 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🗹 F Days Director <u> 384-18-6489</u> March 22, 1933 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at a or 28a-f she t be notified a 1 KYes 2 No Directo Maryland Anne Arundel Snadyside 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1642 7 Is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b Columbia Beach Road 20764 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 **™**Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Warron Hanon Mildred Newman ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shadyside, MD 20764 1642 Columbia Beach Road William Larkin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Inatomy Gifts Registry January 17,2008 Ho 22. Name and Address of Facility Anatomy Gifts 7522 Connelley Drive Scite P. injury ( Hanover, MD Donation 5 ☐ Other (Specify) 21. Signature of Juneral any Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) Due to lovas a consequence of): /Medical Examiner 6511~んる Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed sician and burial-tran Due to (or as a consequence of) P.O. Box 68760 attending physician I for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Vear 4□Pregnant at time of death 5 Other (specify) ed by the 9 I Inknown 9 Unknown signed l d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed?

1 Yes 2 No certificate To the Hospital or Attending Physician; director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No Hospital: ို 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funeral Medical Certification: Division 1 Natural 5 Pending Investigation 1 ☐ Yes 2 🗷 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and trile of certifier 29c. License number 29d. Date signed (Month, Day, Year) ame and address of person who completed cause of death (Item 23a) (Type, Print) SUIL
32. Registrar's Signature Suite 31. Date filed (Month, Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #11, per Inf (876) 2/20/08 TT ment of Health and Mental Hygiene amend #7&12 Per FH G876 2/07/08 TH Reg. No. 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Edward Steve Roth, Jr. 8:08 A 2008 Jan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** U.S.A. Baltimore 1800 Beechwood Avenue If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**⊠**M 2□F <del>83</del> 56 Yrs Director 8,1951 218.60.8539 Dec. MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at Director Baltimore 1 ☐ Yes 2 ₹No Baltimore MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 21221 1800 Beechwood Avenue U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 1970 1 12 Yes 2 I No 1970 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1979 1974 Black, White, etc. 1 Never Married 251 Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical (Give kind of work done during most of working life. DO NOT use retired) **Automobile** College (1-4or 5+) Elementary/Secondary (0-12) Assembly Line Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Edward Steve Roth, Sr. ို Frances A. Humphreys 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Roth/Mother 1800 Beechwood Avenue, Baltimore, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or of 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State Chesapeake Crematory 01.28.08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cafa/Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr. Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dancredu Tieleffalle cancer MUNIK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine sician and burial-transit Division or Vital Records, P.O. Box 68760, Cy that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as the 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown nuer uns certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 30. Name and address of person who completed BAITERY AVE BALTIMURE MA J41 BUMC 7970 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Charles C. Rayfield Jr 2000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SalisBURG NICOMICO 8. Date of Birth (Month, Day, Yea Aug 21, 19 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 5. Social Security Number **Funeral** Months Days Hours Min. 1 ▼ M 2 □ F Maryland 215-20-2358 81 1926 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No ral", or items 23a or 28a-f sh Examiner must be notified Director Crisfield MD Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21817 26860 Clifton Mister Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify: white Specify: þ 3X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) television 12 technician and Mental Hygi is marked other Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Audrey Goldsborough Charles C. Rayfield Sr ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any Injury or other trau 21810 3399 Allen Road Allen, MD Douglas Rayfield/son Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade <sup>22</sup> Name and Address of Facility Board 655 W. Baltimore Street Bal Director Baltimore, MD 21201 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MRTASTATIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Tyes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 KNo 1 npatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury 28h. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1005 8410

State Registrar 31. Date filed (Month, Day, Year)

JAN 3

1

P.O BOX 1733

SAVISBURY UP 21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year IX M **Physician** TIMP 30, 2008 4c. County of Death /Medical RMUNRS City, Town, or Location of Death lity Name (If not institution, give street and number, 4c. Examiner andallstown 8. Date of Birth (Month, Day, 07. 26 Age (In yrs. last birthday **Funeral** 1 ☐ M 2 🗑 F Yrs. Director 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at show 1 Ses 2 No Directo t more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n 21228 death v Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ral", or Items Examiner n Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of the for the Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or Ites 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify 3 X Widowed 4 ☐ Divorced Cepartment of Health and Mental Hygiene.
In portant: If Item 27 Is marked other than "naturenty Injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working lite\_DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omestic omesti 17. Father's Name (First, To Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow , State, Zip Code) 300 21228 Balto. 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory 1 Burial 2 ☐ Cremation 3 ☐Removal from State rownsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service L Balto. Nat 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause or much line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner RENM Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed ENCEPHALOPATH Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-tran Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No autopsy performe this certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To To the Hospital or Attending Privithin 24 hours after death.

To the Funeral Director; After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Notertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 014140 mic 30 2008 JANUAR. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ${\it J}_0$  G  ${\it i}$   ${\it i}$  C  ${\it i}$ 32. Registrar's Signature 31. Date filed (Month, Day, Year)

JAN 3 1 2008 ARMORU State The same Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (Firşt, Middle, Laşt) **Physician** Ø M ourse anuary 27,2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltomore General If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) (In yrs. last birthday) Social Socurity Number 6. Sex **Funeral** 1 □ M 2 F Hours 69 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show ral", or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Kaltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Black Specify: 2 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Domestic permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienc Important: If item 27 is marked other that any injury or other traumatic event, the any once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be attre OUIS ဥ 19b. Mailing Address (Street and Number or Rural Route Number-Gity or Town, State, Zip Code) 19a. Informant's Name/Relationship. (Type. Print) daughter 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State VISON 4 ☐ Donation 5 ☐ Other (Specify) plus Advicency Funeral 21. Signature of Funeral Service Licen ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the di shock, or heart fa Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a conse pence of): Examiner The Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? Yes 2 \( \square\) No this certificate 1 Yes filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manne⊮of Death After Iniury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) raad Year 2008

Registrar DHMH 17 Rev 1/2001

State

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		, FOI	partment of Health and Mertificate of Death	lental Hygier	2000 0/4/4
	, III	Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year
Physic /Med		Margaret 6 Story		1 2	29 Zoo 11:14 a
Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		601 Cornell Street, Apt. 309  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Aberdeen  II Under 1 Year   II Under 24 Hrs.	8. Date of Birth	Harford  9. Birthplace (State or Foreign
Funera Directo		218-48-3149 1 M 2X F 63 Yrs.	Months Days Hours Min.	MAY 27 1	944 North Carolina
		Usual Residence of Decedent			
arylar ehow	_	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1 ☐ Yes 2X No
the M	Director	MD Harford Aberde	en 10f. Zip Code	100	Citizen of What Country?
with 38 or	2	601 Cornell Street, Apt. 309	21001	log.	USA
death ms 2:	Jera	11. Marital Status 12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,
after or Its	by Funeral	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give	II Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No Specify:	nican, etc.)	Black, White, etc.
OO3				1 400	White
15- in 72	olete	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gillie life	cedent's Usual Occupation ve kind of work done during most of work n. DO NOT use retired)	ing	. Kind of Business/Industry
212 With	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	emaker		Own Home
ore, Maryland 21215-0036 ss 1 end 2 should be filed within 72 hours after death with the Maryland is 1 end 2 should be filed within 72 hours after death with the Maryland it Health and Mental Hygiene. Item 27 le marked other than "naturel", or Items 23a or 28a-f ehow other traumatic event, the Medical Examinating the multiple 1 at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maid	den Sumame)
VIOI Duid b Ment Ment arked	2	Lindsey Spear	Darcus	Cass	
Mar 12 sh h and r le m	<b>K</b> 3		O Deilaged Arrows		
Health			O Railroad Avenue,  position (Name of rematory or other place)		MD 21130 . Location - City or Town, State
nor of or of			rematory or other place) rematory, Inc. 1/30		Baltimore, MD
Baltimore, permit. Peges 1 er Depertment of Hea Important: if item: eny injury or other		21. Signature of Funeral Service Licensee H. Williams	22 Name and Address of Facility Cremation Society		
m gare		Steven H. Williams	299 Frederick Road	oi maryia 1, Baltimo	re, MD 21228
		23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Physician		Immediate Cause (Final disease or condition Chronic obsta	rective pulmona	gdise	Onset and Death
/Medica Examine		resulting in death)  Due to (or as a consequence of):		2	
		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	reg disease		
P. E. Si	ğ	cause. Enter Underlying Cause (Disease or injury			
exect on and ial-tra	Examiner	resulting in death) Last c			
tare be executed physician and the burial-transit	dicai	d			
x 68 entifica ling pl	Med	IF FEMALE:			
Box 6 eath certif	lan	23b. Was decedent pregnant in the past 12 months?  4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery  Month Day Year
P.O. Box thet the death cert ed by the ettendin detached for use	Physician/Me	1 ☐ Yes 2 🖼 o 9 ☐ Unknown 9 ☐ Unknown	O Cities (specify)	<u> </u>	
S, P es thet igned b	by Pr		underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
cords, w requires t been signe				1 ☐ Yes	2 No 315 Probably 4 □Unknown
Division of Vital Records, P.O. Box 6: I or Attending Physician: The law requires that the death certific effer death.  Director: After this certificate has been signed by the ettending p in by the tuneral director, page 2 should be detached for use as	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
of Vital Re Physician: The la this certificate has	E S			performed	? death?
Vital Fician: The certificate rector, pag	Be (	25. Was case referred to medical examiner?		h (Check only one)	
Of \Physical Physical this call direct all direct physical dir	2				6 Other (Specify)
ding h. After funer	달	27. Manner of Death 1★Chatural 5 □ Pending (Month, Day Year) 2 □ Accident investigation		28d. Describe how it	njury occurred
Vision of Vita Attending Physician: If death. ector: After this cartific by the funeral director,	fica	2 Accident Investigation 3 Suicide 6 Could not be determined			t and Number or Rural Route Number,
Dis el or la la la la la la la la la la la la la	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Si	tate)
Division ( To the Hospital or Attending F within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	edicai	29a. Certifier tertifying Physician: To the best of my knowledge, de	eath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the within 2 To the complet	₩ We	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
		Elisabeth Tilleros M	D DO05287	8 Ja	nuary 29, 2008
K		30. Name and address of person who completed cause of death (Item 23a) (Type Elisabeth Tilleros 1321 Live	pe, Print)	. Y. A	balama MD 21017
	tate	Elisabeth Tilleros 1321 Live 31. Date filed (Month, Day, Year)  32. Registrar's Signature	1 side luikung )	1111111	المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية
Regis		IAN 3 1 2008 12 1	pode		and place, and due to the cause(s)  Date signed (Month, Day, Year)  IN 44 7 29, 2008  Belcamp MD 21017

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		of Mary		epartmer Certificat			and M		Reg. No.	08	02475
	Physicia	ın	1. Decedent's Name (First, Middle								2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al .	Winifred Spe 4a. Fecility Name (If not institution		umber)		4b City	Town or	Location o	of Death	Januar	y 26, 2	008 v of Death	4:40 P M
	Examine	er	Harford Memo						Grac				rford	
	Funeral Director		5. Social Security Number 577–20–7564	6. Sex 1 □ M 2  F	7. Age (In	yrs. last birth	1445-	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Nov 19	th ly, Year) 1921	9. Birth Cou Ohi	place (State or Foreign intry) .O
	and	ł	Usual Residence of Decedent  10a. State 10b. County		100	c. City, Town	or Location							10d. Inside City Limits
	Maryl -f sho	ţ	Maryland Ceo	cil		C	olora							1 ☐ Yes 2 No
2	r 28a	Funeral Director	10e. Street and Number	)			10f. Zi	Code				10g. Citizen of	What Cou	intry?
6	th wit	a D	958 Firetower	Road				2191	7			U.	SA	
10	tems	ner	11. Maritaf Status	12. Was De Armed	cedent Ever Forces? 20 No	in U.S.	13. Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Orig n, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	)- 14. Ra Bla	ce - Ameri ck, White	ican Indian, , etc.
640PM	s afte	by Fi	1 Never Married 2 Marr 3 Widowed 4 Divorced	ied 1 □ Yes If Yes, 0 Year or	2½ No Sive		1 🗆 Yes	2[ <b>X</b> No	Specify:			Speci	ゕ: Whi	te
\ 	72 hours after death with the Maryland nature!, or Itams 23a or 28a-f ahow itsal Examiner must be notified at	ed	15. Decedent	's Education		16a. I	Decedent's Usu	al Occupa	ation			16b. Kind of E	Business/Ir	ndustry
8 /6 21215-0036	thin 7.	Completed	(Specify only highes Elementary/Secondary (0-12)	<del></del>	(1-4or 5+)		Give kind of wo				ng			
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	o a p >	Be	17. Father's Name (First, Middle, Risque W. Gibs									, Maiden Suma	me)	
$\lambda 6$	should Ind Meni	2	19a. Informant's Name/Relations			19b	Mailing Address	(Street a			C. Rich	er, City or Town	State Zi	n Code)
	nd 2 s lith an 27 is r treu		Kathleen Gome:		er		8 Firet					Marylan		
ē,			20a. Method of Disposition		2		Disposition (Na., crematory or			00	Date	20c. Location		
Ē	Page ment o ant; if jury or		1 ☐ Burial 2 XXCremation 4 ☐ Donation 5 ☐ Other (S)		n State		Cremato			01/2	80\8	Baltimo	ore,	Maryland
$\mathcal{E}\mathcal{D}$ Baltimore,	permit. Pag Department important: i any injury o once.		21. Signature of Funeral Service Thomas Grego	Acensee Or			<sup>2</sup> Chame a Crema 299 F	tion rede	ss of Facility SOC1 rick	ety Road	Of Mary	land,	Inc. arvla	nd 21228
( + k	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List fmmediate Cause (Final disease or condition resulting in death)		caused the each fine.		Acquir	e of dyin	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death  Week
/e, W, N 8760,€g	ate be executed hysicien and he burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		nsequence of								
NAU9 .0. Box 6	that the death certifica ed by the ettending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		birth 2 🗌 gnant at time	Fetal death	3 □Ectopic p 5 □ Other (s)						ate of delive	rery Day Year
Spo.	w requires that been signed b should be deta			lation w			the underlying of	,	en in Part I. RESPO			obacco use cor Yes 2 No	ntribute to 3 ☐ Pro	the cause of death?
Sivision of Vital Record	: The law r	Completed by	Severe Anen	niA							24a. Was auto perfo 1 \( \text{Yes}	ormed?	Were aut prior to co death? 1 \( \sum \text{Yes}	opsy findings available ompletion of cause of 2 No
Vit	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:	1			Othe	200		(Check only			
ion of	nding Phys tth. :: After this e funeral di	ation: To	1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investig	28a. Dat (Mc	Inpatient e of Injury onth, Day Ye	2 ☐ ER/Outs 28b. Ti ar) In		28c. Injury Work	4 🗀 Nu			dence 6 Ot how injury occu		n(y)
Divis	s effe	Certification:	3 Suicide 6 Could r 4 Homicide determ	ined 286. Pla	ding, etc. (S	ipecify)	m, street, factor				City or To	wn, State)		ral Route Number,
	To the Hospital within 24 hours of To the Funeral completely filled	Medical	(Check only 2 Medical one)	g Physician: To t Examiner: On the and ma	he best of my basis of exa inner stated.	y knowledge, imination and	or investigation	i, in my of	pinion, dea	d place, th occurr	and due to the ed at the time,	date and place	, and due	to the cause(s)
	wit To	_	29b. Signature and title of certifie	-200	, M	D			610			O / C	2-8/	68
16.	Stat	6	Mohames Af: 31. Date filed (Month, Day, Year)	ZAL S	O/ S Registrar's	. UNIO	N AVE	H	AVRE	de	GRACE	MA	210	78
	Registra		IAN 3	2008	10.000	d	Loselle	e.						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #1826 perMD.g875. 1/31/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) George Straughn, Sr. 2. Date of Death **Physician** 12:46pM JAN 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore West North Ave If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 22 Year) 26 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** M 2□F Months Days 81 ٧A 212-20-5760 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State 10b. County Baltimore NA 1 X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or U.S.A. 21215 3209 Burleith Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Items 11. Marital Status Black, White, etc. than "natural", or Iten he Medical Examiner 1 Never Married Married 1 ☐ Yes 2X No Black Specify: Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Straughn and Company Elementary/Secondary (0-12) College (1-4or 5+) the Real Estate Broker 12th grade 7 Is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) tem 27 Is marked oth Be Ozzie Clark Warren Straughn ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21215 3209 Burleith Ave, Baltimore, Md Frances Straughn-Wife If Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Iter
any injury or oth 1 Burial 2 ☐ Cremation 3 ☐Removal from State Garrison Forest Vet 2/1/08 Owings Mills, Md 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Parch F, H West
H300 Wabash Ave, Baltimore, Md 21. So at re of Funeral Service Licensee 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Probable Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): physician Physician/Medical the as attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) Yes 2 □ No the 9□ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Tenosis Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an has page 2 performe 1∐ Yes 2IZiNo certificate luncon 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 2 140 6X Other (Specify) Business 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P this funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After Certification: (Month, Day Year) Natural 5 Pending investigation 1 ∐ Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

Box 68760, pe P.0. Records, Division or Vital Physiclan:

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Hospital or Attending 24 hours after death. Director: filled in by the within 24 hours To the Funeral

the

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State Registrar

cal

29a. Certifier

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and addre of person who completed cause of death (Item 23a) (Type, Print)

Greenstree Pd 1838 Gaber MD

and manner stated.

82. Registrar's Statiature 31. Date filed (Month, Day, Year) 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death   Provided				For State		State of M	laryland					nd Mer	ntal Hyg	giene	)		
Private   Priv		*		State Registrar  1. Decedent's Name	e (First, Middle, L	ast)		Cel	uncau	9 01 L	Jealli	2.			2000	3. Time of Dea	tfi? ~~
Securitive   Compared processes   Compared proces	×		_			-							Month	Da		11/13	1 1
Second Boston Freeze   Second Boston Freeze			AC 2. 4	4a. Facility Name (//	f not institution, gi	ve street and number	.)		4b. City,	Town, or	Location of D						
Part   Part			#														
Qualified and processors   This. Country   T	B											Min.	(Month, Day	, Year)	9. Birth Cou		e <i>ig</i> n
State   Carland M. Black   Sarland M. Black   Sar		pu ,					T 100 City	Town or Lo	nation							10d Inoido City Lin	mito
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Rigitaria   Communication	Ma	id 2 s lth an 27 Is r traur					ghter							-	,	•	
Registrate   Committee   Com	re,	s 1 ar of Hea Item 3		20a. Method of Disp	position		20b. PI										
Physician // (Addicated Examiner)  23a. Part I Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardillor or respiratory arrest. Internal behaviors above, or heart failure. List only one cause syneholisms. The feather above and the feath of the cause of the feath of the cause of the feath. Do not enter the mode of dying, such as cardillor or respiratory arrest. Internal behaviors above, or heart failure. List only one cause syneholisms. The feather above and the feath of the cause of the first above and the feath of the cause of the first above and the feath of the cause of the first above and the feath of the cause of the first above and the feath of the cause of the first above and the feath of the cause of the first above and the feath of the cause of the first above and the feath of the cause of the first above and the feath of the cause of the first above and the feath of the cause of the first above and the feath of the cause of the first above and the feath of the cause of the first above and the feath of the cause of the first above and the feath of the cause of the feath of the cause of the first above and the feath of the cause of the f	imo	Page nent c ant: If any or					9							G1e	n Burnie	, MD	
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Physician (Medical Examiner)    Part   Medical Examiner   Medical Exam	ĸ.			23a. Part1. Enter t	he disease, or co	mplications that cause	ed the death	. Do not ent	ter the mod	e of dyin	g, such as ca	ardiac or re	espiratory ar	rest,		Approximate	
Resulting in death   Part				Immediate Cause (	(Final	Her	te	My	car	dial	Tag	fare	ton			Onset and Death	ul
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Cause. Enfort Protesting:  Cause. Enfort Protest	В	LAdminer	7	Sequentially list co	nditions,	b. Due to for e	s a consegu	lence of):	100	40	paju	1				1 year	7
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32. Registrer's Signature  33. Registrer's Signature  34. Date filled (Month, Day, Year)	risio	death death ctor: y the	ficat	3 ☐ Suicide	6 ☐ Could not	be 28e, Place of in	njury - At ho	me, farm, st			162 2 100					al Route Number,	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Elliott Grobaly on 1411 Maduan Park Once Gen Cornie, and 2106  State  31. Date filed (Month, Day, Year)  32. Registrer's Signature		To th withir To th comp	Me	29b. Signature and	title of certifier	01	0		290	. License	number	,		29d. Da		, Day, Year)	
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				31. Date filed (Mon	itn, Day, Year)	2 32. Hegis	trer's Signat	ture	with				1			1	1

Registrar DHMH 17 Rev 1/2001

# **Physician** /Medical **Examiner Funeral** Director death with the Maryland la or 28a-f show t be notified at ns 23a / Items "natural", or Iten edical Examiner filed within 72 hours after Maryland 21215-0036

the

1 and 2 should be Health and Mental

permit. Pages 1 am Department of Heal Important: If Item 2 any injury or other

Baltimore,

P.O.

Division or Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 6:37 AMM 2008 Jayantilal M. Shah January\_27, 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery General Montgomery Derwood Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days 1 MM 2 □ F 83 11/30/1924 India 154-76-5717 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h. County 1 □ Yes 2 K No Funeral Director MD 01nev Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20832-India 3700 Toddsbury Lane 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: Completed by 3 Widowed 4 Divorced Asian Indian 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Education College (1-4or 5+) Elementary/Secondary (0-12) Teacher / Principle 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Suraj Shah Maganlal Shah 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kusumben Shah/Wife 3700 Toddsbury Lane Olney, MD 20832-20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan 28 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 Chesapeake Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Dcensee M00382 Rapp Funeral & Cremation Services Stocked Lohn am 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) STAGE ND Due to (or as a consequence of): 5/A-6-E if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical

Physician /Medical Examiner

for

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has page 2

certificate l

After this

24 hours after death.

within 2. To the I

Hospital or Attending

funeral director,

filled in by

completely

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Completed

Be

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Certification:

Medical

Examine physician and is the burial-trans

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

4□Pregnant at time of death 9□Unknown

3 □ Ectopic pregnancy 5 ☐ Other (specify)

Month Day

23e. Did tobacco use contribute to the cause of death? 2 0 No 3 Probably 4 Unknown 1 □ Yes

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated

24a, Was an autopsy performed 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 DNo 2 **D** No

Year

25. Was case referred to medical examiner? 2 No 1 🗌 Yes 27. Manner of Death 1 **D**Natural

29b. Signature and title of confifier

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

6 ☐ Could not be

2 ER/Outpatient 3 DOA 28h Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

26. Place of Death Check onl one

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

251 E ANGETAM ST. SADIR M. ALI W.D HAGERSTOWN MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year 200 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** A MediCAL MORC BALTIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Days 1 □ 💥 2 🗆 F Months Min Director 218-44-3788 Jun 8, 1947 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 **X**es 2 **N**o Director Maryland N/A **Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5918 Darian Court 21206 U.S.A. **Funeral** 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married □Yes 2 fYes, Give Baltimore, Maryland 21215-0036 1 □ Yes 2 □ No þ Specify Black 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Duty Care Giver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Scott Ethel Murphy ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5918 Darian Court Baltimore, Maryland 21206 Ernestine Chalk Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/29/08 Owings Mills, Md. Garrison Forest Veterans Cemetery 21. Signature of funeral Service Licent 22. Name and Address of Facility MUSIT 75 Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Mari 23a. Part1. E use the disease, or complication shock, or eart failure. List only one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANCER **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy 2 0 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Hnpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Within 24 hours after death.
To the Funeral Director: After 1 Natural 2 Accident (Month, Day Year, Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ca (Check only one) and manner stated. 29b. Signature a nd title of 29d. Date signed (Month, Day, Year)

State Registrar IONGREENEST BALTIMORE MIN 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

-was he

08-00759 Ramona Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

imona Smith	1	State of Maryland / Department of Health and Menial For State  Certificate of Death	ygiene Reg.	No. 20	00 001
	R	egistrar Decedent's Name (First, Middle,Last)	2. Date of Death	av Year	3. Time of Death 2316 hrs
Physicia edical Examir		M Smith	January 27,	2008 4c. County of Death	2310185
{		la. Facility Name (if not institution, give street and number)	n	Baltimore Coul	ntv
		6529 Loch Hill Road Parkville	a 19 Date of Birth/	MM/DD/YYYY) 9. Birti	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Mir	2	Foreig	1
Director	-	213-78-1556 1 M 2XF 51 Yrs. White 25	7/20/	1956	intry) Md.
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any	Ī	10a. State 10b. County 10c. City, Town or Location			1 X Yes 2 No
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Aaryland 28a-f show any 1 at once.	윉	10e. Street and Number			
e Mare Mare Mare Mare Mare Mare Mare Mar	Director	1219 Division Street 21217		USA	can Indian, Black,
i   480 hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Fispanic Origin (Chan Mexican Puer	Specify Yes or No- to Rican, etc.)	White, etc.	can indian, black,
ath v item item	Funeral	1 X Never Married 2 Married 1 Ves 2 X No		D.	Lack
her de		2 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: B  16b. Kind of Business/	
ars af tural	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re-		16b. Kind of business/	madowy
72 hou n "na sal Exp	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	1	Never Wo	rkad
336 thin than than	ompleted	12 Disabled	me (First, Middle, M		red
5-0036 led within 72 hours after death with the Maryland stygene other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once, the Medical Examiner must be notified at once.	0	17 Father's Name (First, Middle, Last)	ice John		
21218 nuld be fill Mental F marked ic event, j	Be	George Sullu	or Rural Route Num	ber, City or Town, Stat	e, Zip Code)
21 hould nd Me is ma	ဥ	1910 Division Str		timore. M	d. 21217
		ETICH OUNCE	Date	20c. Location - City of	r Town, State
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		1 S Y Rurial 2 Cremation 3 Removal from State crematory or other place)			M.J
TOP Pages ent of nt: 1		Western Cemetery 12/	/1/2008	<u>Baltim</u>	
altic mit. ports	l K	Denation 5   Other Specify:  21 Size 1 e of Funeral Service Lice 19   22 Name and Address of Eacility ESTEP Brothers 1300 Eutaw Pla	Funera	l Servic	$\overset{ ext{e,PA}}{.}$ 21217
E E E		1300 Eutaw P12	ace, ball	est, shock, or heart	Approximate interval
Physician		rant I. Enter the dislase, or complications that cause the dear of not enter the mode of dying, such as cardia failure. List only one cause on each line.	,		Between Onset and Death
fedica		Immediate Cause (Final disease a. Choking due to Bolus of Food III All way			00
amine		or condition resulting in death)  Due to (or as a consequence of):			
	_	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):			
	ine	cause. Enter Underlying Cause			
-	Examine	(Disease or injury that initiated events resulting in death) Last			
ox 68760, anth certificate be executed attending physician and	<u> </u>	d.	mb		
e exe	edical	☐ AMENDED1,23a,27,28a-f per ME g878 4/25/08 ar		23d. Date of deliv	erv
760, cate b	Ş	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre	egnancy	Month	Day Year
Box 6876( e death certificate the attending phy	sician/M	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ecropic pre		U	
eath c	i.	1 Yes 2 No 9 V Unknown 9 Unknown			of dooth?
the de	3   2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?  Probably 4  Unknown
P.O. es that the signed by	2		_		
<b>S,</b> quire en sig	1		24a, Was	prior prior	autopsy findings availab to completion of cause of
Orc aw re				ormed? death	
Rec The 1	Completed	26.Place of Death (Cl			
al F	ector,	25. Was case referred to medical	Nursing Home 5	Residence 6 🗸 0	ther: Scene
of Vital Records, ng Physician: The law require the this certificate has been at		1 V Yes 2 No	-	e how injury occurred	
of ng Pl	uneral	27. Manner of Death 20a. Date of Injury	_		3 1-1
i tendi	the	Natural 5 Pending Investigation Find 1/27/08 Find 10.59n Pending Investigation Place of Injury - At home, farm, street, factory, office building, etc.		choked on for (Street and Number of	r Rural Route Number, C
Division tal or Attendi rs after death.	in by	3 Suicide 6 Could not be	or Town	, State) ch H <u>ill Rd Pa</u>	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Functal Director: After this certificate has been signed by the attending phys.	filled in by the tune	4 Homicide determined (Specify) Group home			
Hos 24 hc	etely	298. Celulel 4 County in a Physician. To the hest of my knowledge, death occurred at the time,	urred at the time, da	te and place, and due	to the cause(s)
o the	dwo	and manner stated.		29d. Date signed	(Month, Day, Year)
- * -	°	29b. Signature and title of certifier  O.C.M.E.	OCME	January 28, 2	
W.	1	The of M. K. & Trying			
repr	0	30. Name and address of person who completed cause of death (Item 23a)  The address M. King, Jr. MD. Assistant Medical Examiner 111 Penn Street, Balti	imore. MD 212	01	
17. Oh.		Theodore IVI. King, St., IVID.			
4	Sta				
Por	rietr	JAN 3 1 2008 1 2008 1 200 1 20			

DHMH 17 Rev 1/2001 OCME 2006

			1 - State Registrar	,	Ce	rtificate of	Death		Reg. No.	0000	
: S	Physic		Decedent's Name (First, Middle, L.  ROBERT L. WILL	,				2. Date of D	eath	2008 <sup>ar</sup>	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, gi SUMMIT PARK HEAI REHABILITATION (	ve street and number)			or Location of Death			County of Death BALTIMOR	
	Funeral Director		5. Social Security Number 6. 223–46–0940	Sex 7. Age (In yrs. 1X M 2□F 70	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D	irth 1937		ace (State or Foreign TNIA
	death with the Maryland ms 23a or 28a-f show r must be notifled at	Director	Usual Residence of Decedent  10a. State 10b. County  MD N/A		y, Town or Lo	TIMORE C	ITY			11	0d. Inside City Limits 1 X Yes 2 □ No
	th with the 23a or 2	al Dire	10e. Street and Number 201 N. WASHINGTO	ON ST., APT. 11	.01	10f. Zip Code 2121	3		10g. Citi	zen of What Coun	try?
980	ours after ral", or ite Examine	by Funeral	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Sean, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)		14. Race - America Black, White, of Specify: BLAC	etc.
15-0	in 72 hc	Completed	15. Decedent's E (Specify only highest gi	rade completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wor d)	king	16b. Ki	nd of Business/Ind	lustry
1212	be filed within 72 ho ital Hygiene. dother than "natu event, the Medical		Elementary/Secondary (0-12) 12TH	College (1-4or 5+)	LABO					AFOOD BUS	SINESS
land	12 should be filed within 'h and Mental Hygiene. 7 Is marked other than "	To Be	17. Father's Name (First, Middle, Las CORBIN WILL	,			18. Mother's Nan	ne (First, Middle N HARRI		Surname)	
, Maryland 21215-0036	ges 1 and 2 should it of Health and Mer If item 27 Is marke or other traumatic		19a. Informant's Name/Relationship DEBORAH GIBSON /	DAUGHTER	1128	ST. AGNI	and Number or Ru ES LANE,				Code)
Baltimore,	permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any Injury or other trau		20a. Method of Disposition  2XBurial 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Speci	Removal from State BRA	NCHES IRCH CI	osition (Name of RUNN BAP EMETERY	/	Date 02/08	AMEI	LIA, VA	
Ball	permit Depart Import any In		21. Signature of Funeral Service Lice	nsee			ess of Facility HORTY HEIG				
68760, <	Physician Medical Examiner as the burial-transit	Medical Examiner	23a. P.M. Ther the prease, or consiste, heart alure. List only Immunation and Community Immunation and Community Immunation and Community Immunation and Community Immunity Im	pplications that caused the depart one cause on each line.  a. Due to (or as a consequence to (or as a	TA uence of):	TIC.	and the same of			NOMAC	Approximate Interval Between Onset and Death
O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of do 9 ☐ Unknown	Ideath 3[	Ectopic pregnanc	у		2	23d. Date of delive Month	ry Day Year
rds, P.	quires that en signed b uld be deta	by	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	nderlying cause giv	ven in Part I.			ise contribute to th ☐ No  3 ☐ Prob	0.0
Division or Vital Records,	: The law recate has been page 2 sho	Completed						24a. Was auto perf 1 Yes	s an opsy formed? 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	prior to con death?	osy findings available npletion of cause of
r Viit	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Oth	26. Place of Dea			6 □Other (Specify	()
ion o	Attending Phradestrians of the funeral of the funeral	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe			,
Divis	To the Hospital or Attending Physician: The law within 24 hours after cleath.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Specify	v)			City or To	òwп, State,		
	To the Hospital or A within 24 hours after To the Funeral Directional Completely filled in by	edical	29a. Certifier (Check only one)  Certifying Pi  2 Medical Exa	hysician: To the best of my know miner: On the basis of examinat and manner stated.)	wledge, deat tion and/or in	h occurred at the ti- vestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time	e cause(s) e, date and	and manner as st place, and due to	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of a rtifier		0	29c. Licens	e number	٦		e signed (Month, L	
	H		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)	DUP HER	5	Jar	wany 6	19,2008
	Sta	ote.	31. Date filed (Month, Day, Year)	32/ Registrar's Signar	ture .	3350	Wilk	ens t	411e	#307 (	Batto. MD
	Sta Registr			08	l has	all I					والمحال

Division or Vital Records, P.O. Box 68760.

3altimore, Maryland 21215-0036

within 24 hours after death To the Funeral Director:

Registrar DHMH 17 Rev 1/2001

10+1

29b. Signature and title of certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MATEEN AWAN

10802 HICKORY RIDGE RD COLUMBIA

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0062634

29d. Date signed (Month, Day, Year)

21044

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** М Douglas В. Welch January 20 2508 /Medical 4c. County of Deat 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Square If Under 24 Hrs If Under 1 Year 8. Date of Birth (Month, Day, Year) January 1, 1938 5. Social Security Number /6. Sex vrs. last birthday **Funeral** Months Days Hours Min 1 XM 2 ☐ F Maryland 70 216-34-3201 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show notified at 1 ☐ Yes 2X No Director Maryland Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a or Injury or other traumatic event, the Medical Examiner must be I 21237 USA 1212 White Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14 Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Roofing 12 years Boiler Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be ealth and Mental Unknown Unknown ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1212 White Avenue, Rosedale, Maryland Important: If item 27 any Injury or other tr Renee Welch wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory 2, 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee, Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dyin , such as cardiac or respiratory arrest, shock, or heart failure. Hist only on so on each line. Immediate Cause (Final Physician 10 disease or conditior resulting in death) /Medical Due to (or as a consequence of Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.O. ed by the 9☐Unknown 9 DUnknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown been sign Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autons perform 1∐ Yes 2 No Division or Vital Attending Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 □ DOA ည this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu death. 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) dress of pers who completed cause of death (Item 23a) (Type, Print) der 9000 (U.30. Registrar's 6 State

DHMH 17 Rev 1/2001

Registrar

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Charles Joseph W			State	of Maryland	/ Depar	tment of	Health	and	wenta	ппуу			20	08 0248
	Re	For State			Cert	ificate of	Deam			12	Reg Date of Death	. No.		3. Time of Death
Physician	/ 1.	Decedent's Name (	First, Middle,Las				7	T7.7				Day Ye	ear	1921 hrs
Medical Examine		Charles		Joseph		Wa	b. City, To	IV	eation of I		affually 20	4c. County	v of Deat	h
Han.	4			e street and number)		"	Hagers		Cation of L	Deau		Washi		
		11 W Baltimo					If Under		If Under 2	24Hrs 8	Date of Birth	(MM/DD/YY)	/Y) 9. Bi	rthplace (State or
Funeral	- 1	. Social Security Nur			je (in yrs. las		Months	_	Hours	Min			Fore	ountry Maryland
Director	2	216-82-969	96   <sub>1</sub> [X	M 2 F		14 <sub>Yrs</sub> .					May 15	, 1963		vial y land
	_	Isual Residence of D			40- 00-	Town or Locati	00							10d. Inside City Limits
, any	1	0a. State	0b. County		Tuc. City,									1 Yes 2 X No
and show	5 1	Maryland		ton	<u> </u>	Hager	10f. Zip				110	g. Citizen of	What Co	untry?
Aaryl.		0e. Street and Numb		14	607		,	1740				USA		
reath with the Maryland or items 23a or 28a-f show must be notified at once.		11 W. Bali	timore S	Street Apt					1. Odele	-0 / 0	ifu Voc or No		ce - Ame	erican Indian, Black,
with with be no		1. Marital Status		12. Was Deceden Armed Forces		S. 13. Wa	is Deceden es, specify	it of Hisp Cuban,	Mexican, F	Puerto Ri	ify Yes or No- can, etc.)		hite, etc.	
r iter	5	1 X Never Married		1 Yes 2	X No		Yes 2					Specif	y: Wh	ite
after al", o	<u>\$</u>	3 Widowed		d If Yes, Give Year or Dates:		16a. Deceder				ind of wo	rk done	16b. Kind of		
ours	ฐโ			only highest grade co		during m	ost of work	king life. I	DO NOT u	ise retire	d)			
an "r	Completed	Elementary/Secon	idary (0-12)	College (1-4 or	5+)	וס	oral 1	Doci	oner			Fl	oris	st
withir ene.	ĔL	12 years 17. Father's Name (F	Ti i Middle Nee	4)		FIC	JI dI	1	8. Mother's	Name (	irst, Middle, N	Maiden Surna	me)	
Hyge d oth		Charles J							Alio	ce L.	Fort			
121 d be f lental arke		19a. Informant's Nan	ne/Relationship	Type Print )		19b. Mailin	g Address	(Street	and Numb	ber or Ru	ral Route Num	ber, City or 7	Town, Sta	ate, Zip Code)
Shoul Shoul	_	Alice L.			her	6354	Caro	Tra	ce, N	Mecha	anicsvi	lle, V	7A 2	23111
nd 2 alth a mark		20a. Method of Disp		7	20b.	Place of Dispo	sition (Nam	ne of cerr			Date	20c. Locati	on - City	or Town, State
of He If ite	- 1	1 Burial 2	XCremation 3	Removal from S		crematory or o					uary 2008	Ral+i	more	e City, MD.
Page Page ment tant:		4 Donation 5	Other Specia	fy:	вау	view C			of Facility					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	- 4	21 Signature of Fur	0 (		01	/ 17	110 0	-17-	D	aint	Ome Of Road,	Dunda	lk Mo	d. 21222
m go H.E		Mino	nu (	nplications that cause each line.	ed the de di	Do not enter	the mode of	of dying,	such as ca	ardiac or	respiratory arr	est, shock, or	r heart	Approximate Interval
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Medical.	j	Immediate Cause (For condition resulting	Final disease	a. Hepatic st	eatosis	and cir	rhosis	S						
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d d	Ха	events resulting in	death) Last	Due to (or as a co	nsequence	or):								
Division of Vital Records, P.O. Box 68760, within 24 buts after death certificate be executed within 24 buts after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 buts after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transit	cal			d			100							
Box 68760, e death certificate be exert the attending physician red for use as the burial.	훓	X UNPENDED		#23a,27,p	erME,g8	376 <u>,</u> 2/14	<u>+/08 TI</u>	<u>r</u>				23d. Da	te of deli	very
Box 68760, e death certificate be the attending physic of for use as the bur	sician/Medi	IF FEMALE: 23b. Was decedent	pregnant in the	23c. If yes, out			Fetal death	3	Ectopi	c pregna	ncy	Mor		Day Year
68 certif	ciar	past 12 months	3?		t at time of d		Other (Spe							
Sox death	ysi	1 Yes 2 1		a Olikilowi					- 25		Tan Div			e to the cause of death?
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tal Records, P.O. cian: The law requires that the certificate has been signed by: ector, page 2 should be detach	d by	ļ:												e autopsy findings available
Division of Vital Records, that or Attending Physician: The law requir ranker death. After this certificate has been stilled in by the funeral director, page 2 should I led in by the funeral director, page 2 should I	Completed	1									24a. Wa:	ppsy	prio	r to completion of cause of
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tal ician: certi	Be	examiner?	p	Hospital:	atient 2	ER/Outpatie	ent 3	DOA	Other <sub>4</sub>	Nursir	g Home 5	Residence	6 🗸 (	Other: Scene
fVi Physi erthis	유	1 Yes 27. Manner of Dea	2 No	28a. Date of (Month, D		28b. Time	of Injury	28c. Inj	ury at Wor	rk?	28d. Describ	e how injury o	occurred	
n oding	ü	1 X Natural	5 Pendir		ley,Year)	1		1	Yes 2	No				
SiO Atten deatl ector:	cati	2 Accident	Investi	gation 28e. Place	of Injury - At	home, farm, s	treet, facto	ry, office	building, e	etc.	28f. Location	(Street and	Number	or Rural Route Number, City
Division of Vital Rec quita or Attending Physician: The I ours after death. Ther this certificate I reral Director: After this certificate I	Certification:	3 Suicide	6 Could determ	not be	,.,						or Town	, State)		
Spita hours mera y fille		4 Homicide			of my knowle	edge death or	curred at the	he time,	date and p	olace, and	due to the ca	use(s) and m	anner as	stated.
To the Hos within 24 h To the Fu	<u> </u>	(Check only one)	Medical Exam	iner: On the basis of	examination	and/or invest	igation, in r	my opinio	on, death c	occurred	at the time, da	te and place,	and due	to the cause(s)
Tott withi Tot	Medical	29b. Signature and		and manner sta	ted.				ns <b>e</b> numbe		-	29d. Dat	e signed	(Month, Day, Year)
	2	255. Signature dil	$\cap$	20/ /				0.0	C.M.E.			Janua	ry 29,	2008
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Panie	State		JAN	T COORSE	Sept Section	a real of								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year PM January 27, 2008 Kick WILSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown
r1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 11 South Walnut Street Apt. 202 Washington 5. Social Security Number If Under 1 Year Months Days 7. Age (In yrs. last birthday) **Funeral** 032-38-3191 Director Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other that matte event, the Medical Examiner must be notified at any Injury or other traumafte event, the Medical Examiner must be notified at 1 XYes 2 □ No Director Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Walnut Street 21740 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 Yes 2 No If Yes, Give UNKAGWA Year or Dates 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Trucking Freight Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Frederick Wilson Marie Louise Aigeltinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Loving Terrace Susan Slenker Palmyra ,VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry January 28, 2008 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Sergice Licensee Anatomy Gifts Registry M21076 Drive Suite P. Hanever, M21076 7522 Connelley Drive Suite 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on #ich line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of as the burial-transit death certificate be executed and Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical IF FEMALE: signed by the attending be detached for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco, use contribute to the cause of death? Division or Vital Records, 2□ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1∐ Yes 2 No 2 🗆 K 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident completely filled in by the 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dic ASS 111 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 1 2008 Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland /	Depa <i>Cei</i>	artmen rtificate	t of H e of L	lealth a Death	and M		giene Reg. No	and all 47, 475,	02	486
	Dhusisi		1. Decedent's Name (First, Middle, La	st)							2. Date of De. Month	ath Da	y Year	3. Time	of Death
v	Physici /Medio		Elsie M. Whiteh	ead							Jan. 24	-	008	6:45	A M
	Examin	er	4a. Facility Name (If not institution, giv						Location of	of Death		4c.	. County of Deat	h	
			Genesis Health ( 5. Social Security Number 6. S		e (In yrs. last bi	irthday)	Seve:		Park If Under	24 Hrs.	8 Date of Birl	th.	A.A.	hnlace (Stat	e or Foreign
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			Usual Residence of Decedent		72							1/1.		500	LIGHT
	how		10a. State 10b. County		10c. City, Tov	vn or Lo	cation								City Limits
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	er de Items	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 Tyes		13.	was Deced If Yes, spec	ent of Hi	ispanic Ori in, Mexicar	gin? (Sp 1, Puerto	ecify Yes or No Rican, etc.)	-	Black, White	e, etc.	
36	Irs aff	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	••		1 🗆 Yes	200	Specify:				Specify: Wh	ite	
5-0036	72 hours after death with the Maryland Instural', or Items 23s or 28e-f show disal Examination met be inclified at	ted	15. Decedent's E	ducation	168	a. Dece	dent's Usua kind of wor	al Occupa	ation	* af wark	ina	16b. K	ind of Business/	Industry	
215	thin 7	ag l	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	DO NOT us	se retired	()	t or work	ing				
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Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. If the lith and Mental Hyglene returns 23a or 28e-f show item 27 is marked other than "netural", or Items 23a or 28e-f show other treumatic event, the Medical Examinar must be rediffied at		19a. Informant's Name/Relationship (				•						or Town, State, 2 <b>011</b> /. /.	up Code)	
	os t and of Health item 27		Laurie Hill/gran	id-daugnte	20b. Place of cemete						evern,		cation - City or	Town, State	
õ	00		1 ☐ Burial 2 ☐ cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	Chesa					01 2	8.08	Re1	tsville,	MD	
Baltimore,			21. Signature of Funeral Service Lices		100382										D Λ
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	Physician		Immediate Cause (Final disease or condition	. advar	/	1	ama	in t	70					Onset ar	
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18	and and II-tran	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):									
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687	The law requires that the death certiticate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medical		0.											
Box	leath certitics attending pl	M	IF FEMALE: 23b. Was decedent pregpant	23c. If yes, outcome		<b>.</b>	75-4	1071				100	23d. Date of del	ivery	
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P.O.	that the de ed by the detached	hys	9 🗆 Unknown	9□ Unknown											
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ē	after Dire	erti	4 Homicide	building, et	c. (Specify)						City or To	vn, State	9)		
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Pt	nysician: To the best	of my knowledg	je, deat	h occurred	at the tin	ne, date an	d place,	and due to the	cause(s	) and manner as	stated.	- (-)
	he Hi in 24 he Ft pletel	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	ated.	na/or in	vestigation	, in my of	pinion, dea	un occur	ed at the time,				
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						111	4	0:	10 /	$\alpha$	)	/	27-	XVO	8
	6		30. Name and address of person who	completed cause of d	eath (Item 23a)	(Туре	Print		. 4.	11.11	M. Ule	·	11/21	110	1110
			31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	Va	Ier	ans	1/4	141	VIIVA	SV	11210	(1)0/	1108
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State of Maryland / Department of Health and N	Mental Hygiene			
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			For State	State of		nd / Depa		Health and M	ental Hygi	ene	
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	/sicia ledic	al	Larry Wayne Y	enzer					Month	30, 2008	11:07 AM
Exa	amino	er	4a. Facility Name (If not institution		ber)			or Location of Death		4c. County of Death	
-	3.00		Gilchrist Cen  5. Social Security Number		Age (In vrs	last birthday)	Towso	n If Under 24 Hrs.	8 Date of Birth	Baltimo	
Fune Direc			219-46-6883 Usual Residence of Decedent	1 M 2 □ F	. Age (III yis.	60 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Mar 10,	1947 Colu	pplace (State or Foreign untry)District of Mbia
land	=		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation	-			10d. Inside City Limits
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Maryla d 2 should th and Men 7 is marke	E	၉	19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailir	ng Address (Street			City or Town, State, Z	ip Code)
and 2:			Sharyn Yenzer,							ott City, N	
or Healt	ome	- 72	20a. Method of Disposition		20b. I	Place of Dispo	osition (Name of matory or other pla	D D	ate 2	Oc. Location - City or 7	TOWN, State
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Baltimore, permit. Pages 1 ar Department of Hea Important: If item	- J		21. Signature of Funeral Service			22	Name and Addre	ess of Facility	700   I	Baltimore,	Maryland
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COICS, P.O. BOX 68/ w requires that the death certificate been signed by the attending phys	action to use as	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2□Feta ntattime of o	al death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		23d. Date of deli	very Day Year
S, F s that med b		by P	Part II. Other significant conditio			-	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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The I	age of	E							autopsy perform 1 Yes 2	ed? death?  ☐ No 1 ☐ Yes	ompletion of cause of 2 ☐ No
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifical controlled willed in by the funeral director.		Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ation	f injury - At h , etc. <i>(Specii</i>	ome, farm, str	M 1 □	Yes 2 □ No 2	8f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
the Hospita in 24 hours the Funera	and displaying	edical	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical E	g Physician: To the be Examiner: On the bas and manne	is of examina	owledge, deat ation and/or in	vestigation, in my	opinion, death occurre	and due to the cau ed at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
Vitt	3	Σ	29b. Signature and title of certifier	1 /	2		29c. Licens			d. Date signed (Month	
			Je Most	my the	5.	nu)	200	2 400		MUINY	20, 5008
15			30. Name and address of person w	1 6 3m	C 6	761	Print) N. Ch	ules St.	Pali	4. md :	30, 2008 2120/2
Sau Sau	Stat	е	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa	ature	1. 11.				

State Registrar

JAN 3 1 2008

DHMH 17 Rev 1/2001

Physician:

or Attending

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Paula Anne Young 23, /Medical 2008 January 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Timonium

Vear | If Under 24 Hrs. | Min. Stella Maris Hospice Baltimore 8. Date of Birth (Month, Day, Oct 19, 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🕅 F 39 Oct Maryland Director 216-86-0165 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County show a or 28a-f sh 1 ☐ Yes 2√ No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be no 444 Lakewood Avenue 21224 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 N Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Bud Long Deborah Anne Mason Cooper 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Mason/mother 9 E. Fort Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Struce licensee Rona Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director l Baltimore, MD 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ESOPHAGEAL CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner buria -trar Due to (or as a consequence of): attending physician Physician/Medical as the asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy δŗ in the past 12 months? 1 ☐ Yes 2 **X** No Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 1∐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Certification: To 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Use Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and fitle of certifier 29d. Date signed (Month, Day, Year)

State Registrar TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15 QUIDT 0 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/08/1950 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) 6 Sex Months Days Hours Min 1 M 2 □ F Maryland 220-56-1900 57 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland | Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 408 Warwick Place 21037 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer W. Aisquith Anna Mae Whittington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra L. Aisquith/Wife 408 Warwick Place. Edgewater. Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation Hillcrest Cemetery 01/19/2008 | Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature f Funeral Service 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 0201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ĮV. 1 disease or condition resulting in death) Due to (or as a consequence of): 4 MOS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 📋 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of D ath 1 [Matural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation

The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760 attending physician for use as the buria or Attending Physician;

after death. Director: After

**Physician** 

Examiner

**Funeral** 

Director

"natural", or Items 23a or 28a-f show dical Examiner must be notified at

the Medical

Director

Completed by Funeral

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me

Physician

/Medical

Examiner

Examiner

Physician/Medical

ģ

Completed

Be

Certification: To

2 Accident 3 ☐ Suicide

4 ☐ Homicide

29a. Certifier

altimore, Maryland 21215-0036

/Medical

within 24 hours a To the Funeral L completely filled Medical State

and manner stated. 29b. Signature and title of certifique 29c. License number

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person wild completed cause of death (Item 23a) (Type, Print)

> 5 2008

6 ☐ Could not be

strar's Signature 31. Date filed (Month

Division or Vital Records, P.O. Box 68760,

Registrar

State

mpletely filled in by

Medical

within 24 hours at

4 Homicide

(Check only one)

29b. Signature and title of certifier

Jay Rhee, M.D.

JAN 1 5 2008

31. Date filed (Month, Day, Year)

29a. Certifier

Bestgate Rd., Annapolis, Maryland 21401

and manner stated.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Don	ald Lee Arm		1- For State	State of N	Marylan		tment of	f Health and f Death	Menta	al Hygi		- 11-	200	8 021.9
	Physici		Registrar  1. Decedent's Name (First, Mi	ddle,Last)							ate of Death	g. No. 1	Andrea Series Co.	3. Time of Death
Me	dical Exami		Donald Lee	Armst	rong					J.	nonth anuary 8,	Day 2008	Year	0857 hrs
			4a. Facility Name (if not institu			per)		4b. City, Town, or L	ocation of	Death			ounty of Death	
1			Wheaton Regional	Park				Wheaton					ntgomery	
	Funeral		5. Social Security Number	6. Sex	7.	Age (In yrs. las	t birthday)	If Under 1 Year	If Under Hours	24Hrs. 8. Min.	Date of Birtl	h(MM/DD	YYYY) 9. Birt Foreia	hplace (State or
	Director		215-52-8018	1 X M	2F	59	Yrs	Months Days	Hours	IVIII).	Aug.	22,	1948 Co	n Tennessee
	>-		Usual Residence of Deceden			I40 00 7								40 Limite Oite Limite
	w any		10a. State 10b. Cour	ty		10c. City, 1	own or Locat	tion						10d. Inside City Limits  1 Yes 2 No
	land f sho	tor	Maryland	Montgo	mery	unkr	own	_						mknown
	Mary r 28a ed at	Director	10e. Street and Number					10f. Zip Code			10	g. Citizen	of What Cour	ntry?
	death with the Maryland or items 23a or 28a-f show must be notified at once.		unknown					unknown					USA	
	th wi tems	Funeral	11. Marital Status 1 Never Married 2		Mas Deced Armed Ford	lent Ever in U.S. es?		as Decedent of Hisp es, specify Cuban,				14.	. Race - Ameri White, etc.	can Indian, Black,
	er dea	Fui		1 Divorced If Yes	Yes	2 X No		Yes 2 No	specify:			C.,	a a ife u	
	rs aft ural" mine	by	15. Decedent's Education (S	LOT D	ates:	completed) 1	16a Deceder	nt's Usual Occupation		nd of work	done		ecify: Wh	ite
	2 hou "nat	ted	Elementary/Secondary (0-1		College (1-4			ost of working life.					0. 200000	
	36 thin 7 than than	nple	,		2	,		Informati	on Te	echno	logy		Comput	er Science
	5-0C ed wir lygier other he M	Completed	17. Father's Name (First, Mid					1	8.Mother's	Name (Fir	st, Middle, M	laiden Su	rname)	
	<b>21215-0036</b> Juld be filed within 72 hours after death with the Maryland Mental Hygiene. Mental Hygiene amarked other than "natural", or items 23a or 28a-f she ic event, the Medical Examiner must be notified at once	Be	William Tru	ett Arı	mstror	ng		He	elen M	Medei	ros			
	re, MD 21, 1 and 2 should b I Health and Men fitem 27 is mar er traumatic eve	P	19a. Informant's Name/Relation	nship (Type, I	Print)		19b. Mailin	g Address (Street	and Numb	er or Rura	Route Num	ber, City	or Town, State	, Zip Code)
	imore, MD 2 Pages I and 2 shoul ment of Health and M tant: If item 27 is m or other traumatic.		Lauri-Ann Mc	Hugh/Da	aughte			Howard Co						
	s l ar of Hea If ite		20a. Method of Disposition  1 Burial 2 X Crema	ion 3 R	emoval from	State cre	ematory or ot		- 1	Jan	ete • 17,		ation - City or	Town, State
	Page nent cant; or off		4 Donation 5 Other	-		Metr	ropoli	tan Crema	tory	20		1	exandr:	ia, Virginia
	Baltimore, permit. Pages 1 an Department of Her Important: If ite		21. Signature of Funeral Serv	11				Name and Address				-0.50		
	E		1 2000	uu		<b>7</b>	150	ancıs J. <u>O Univer</u> s	ity I	ins F	uneral	Hom Silve	e inc. <del>r Spri</del>	og MD 20901
	Physician /Medical	1	23a. Part I. Enter the disease failure. List only one cau	or complications se on each lin	ons that cause.	sed the death. E	Do not enter t	the mode of dying, s	such as car	rdiac or res	spiratory arre	est, shock,	or heart	Approximate Interval Between Onset and
	taminer		Immediate Cause (Final dise			shot Wound								Death
Sol			or condition resulting in death	, Duc i	o (or as a co	onsequence of):								
		-	Sequentially list conditions, if any, leading to immediate	b Due t	o (or as a co	onsequence of):								
		Examiner	cause Friter Underlying Cau (Disease or injury that initiate	c										
6	lsi d	Ξxa	events resulting in death) La		o (or as a co	onsequence of):								
V	O, e be executed ysician and burial - transit		LINIDEAUDED	d										
	O, e be e: sicial burial	edical	UNPENDED		IENDED									
	tal Records, P.O. Box 6876l cian: The law requires that the death certificate certificate has been signed by the attending phy ector, page 2 should be detached for use as the t	cian/M	IF FEMALE <sup>-</sup> 23b. Was decedent pregnant i	the 23	Live birt	tcome of pregna		etal death 3	Ectopic	pregnancy			Date of delivery onth	/ Day Year
	x 68 h cert tendir use a	icia	past 12 months?	4		nt at time of deat	h - =	ther (Specify)		prognancy		4		, , , ,
	Box e death c the atten ed for us	Physi	1 Yes 2 No 9	Jnknown g	Unknow	n								
	O. nat the	by P	Part II. Other significant cor	ditions cont	ributing to d	leath but not res	ulting in the	underlying cause gi	ven in Par	t I.				the cause of death?
	signe ires th		ļ								1 Yes	2 🗸 N	lo 3 Prob	Dably 4 Unknown
	ords v requ	lete									24a. Was a			topsy findings available completion of cause of
	of Vital Records, g Physician: The law requir ther this certificate has been s neral director, page 2 should I	Completed									perfor	med?	death? 1 ✔ Ye	es 2 No
	tal Recition: The cortificate		25. Was case referred to med	ical		<del></del>		26.Place	of Death (0	Check only				
	Vita ysicia his ce direct	o Be	examiner? 1 ✓ Yes 2 No	Hospit	ial: 1 Inp	atient 2 E	R/Outpatien	t 3 DOA	Other _	Nursing H	ome 5	Residenc	e 6 🗸 Othe	r: Scene
	n of Vit ding Physic 1. After this c	-	27. Manner of Death		28a. Date of	Injury 2	28b. Time of	Injury 28c. Injury	y at Work?		d. Describe h		occurred	
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	Division tal or Attendi rs after death. al Director: /	ijij		* Cottigution		The second second		et, factory, office bu	uilding, etc	. 28f			Number or Ru	ıral Route Number, City
	Dital ours a cral I	Cert	4 Homicide	etermined	(Specify)	Woods				Wh	or Town, S eaton Reg	ional Pa	rk, Wheaton,	, MD
	Division of Vital Records, P.O. Box 6876.  To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	al (	( Olivon Olly	-		-		rred at the time, dat						
	To the within To the Compl	Medical		and	he basis of manner stat		d/or investiga	ition, in my opinion,		urred at the	e time, date a			
		Σ	29b. Signature and title of cer	tifier	. ^			29c. License					- ,	nth, Day, Year)
-	10		( laxur	vile	Us)			O.C.N	Л.E.			Janua	ry 9, 2008	
	-		30. Name and address of per	•		,								
			Laron Locke MD.	Assistant	-			n Street, Baltim	nore, ME	21201				
	Si Regis	tate fran	31. Date filed (Month, Day, Ye	2003	32. Regi	strar's Signature	Speed	E)						
	Regis	GICL	01111			Pull July	Jan -							

DHMH 17 Rev 1/2001

Registrar

P.O. Box 68760, or Vital Records, Division

Medical State

Willan

29d. Date signed (Month, Day, Year)

056950

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NNAEMEKA Aggieln 1411 Malison Park Brive #16 Glen Brrnie MD

Agajeln 15 2008 31. Date filed (Month,

29b. Signature and title of certifier

29a, Certifier

2. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 17, 18 per fb 8876 2-7-08 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Day Verle Benassi-Ori January 5, 2008 /Medical 5:50 p 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 18605 Azalea Drive Derwood Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🛛 F Director 478-09-8968 93 Dec. 6, 1914 Iowa Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland | Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18605 Azalea Drive 20855 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ <sup>Specify:</sup>Caucasian 3 M Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public School 18. Mother's Name (First, Middle, Maiden Surname)
Clara Alida Perryman 17. Father's Name (First, Middle, Last) Be Harland Fay Breed Harlan Breed ည crryman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Richard Benassi - Son 18605 Azalea Drive, Derwood, Maryland 20855 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 1/16/2008 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Ehler the infease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Immediate use (Final disease or condition resulting in death) **Physician** Congestive Heart Failure /Medical Due to (or as a consequence of) Examiner Aortic Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No certificate has the rector, page 2 s autopsy 2 X No 1□ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 NR Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending investigation n 24 hours after death.

le Funeral Director: Af 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 hor To the Fune completely fi one) 29b. Sign. 29c. License number and title of certifier 29d. Date signed (Month, Day, Year) W) D0064615 1/10/2008 and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Ge<u>nevieve Wroblewski</u>

JAN 15 2008

31. Date filed (Month, Day, Year)

32 Registrar's Signature

1355 Piccard Drive, Rockville, Maryland

		-	For State Registrar	State of Ma	ryland /		irtment of H <i>tificate of L</i>			giene Reg. No. 4	2008	0245	95
	Dhysisis	_	1. Decedent's Name (First, Middle, Last,						Date of Dea     Month	ath Day	Year	3. Time of Deat	
	Physicia /Medic		Rona1d	Scott	Buice				January	_		2:15 P.	M
	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or		1		ounty of Death		
			5 Apache Court	7 400	(In yrs. last b	isthday)		rsburg If Under 24 Hrs.	8. Date of Birt		ontgome	ry lace (State or Fore	eian
	Funeral		5. Social Security Number 6. Security Number 115	M 2□F		Yrs.	Months Days	Hours Min.	(Month, Day	v, Year)	Coun	ington, I	
	Director		214-36-3928 Usual Residence of Decedent		67				Dec. IC	, 194	Wasii.	ington, i	<i></i>
	/land ow at	Ì	10a. State 10b. County		10c. City, To	wn or Lo	cation				1	0d. Inside City Lin	
	Mary Fied	ţo	Maryland Montgom	erv	Gai	Lthei	rsburg					1 □ Yes 2 🔀	No
	r 28g	Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cour	ntry?	
	h wit		5 Apache Court				2087	78		Un	ited St	ates	
	deat ems	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?		13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	. 14	. Race - Americ Black, White,		
0	after or It		1 ☐ Never Married 2 ☑ Married	1 Yes 2 N If Yes, Give Year or Dates:	∘ 1963~		1 ☐ Yes 2X No	Specify:		1	pecify:		
9	ural",	d by	3 Widowed 4 Divorced				dent's Usual Occup	otion	-	16h Kind	Wh of Business/In	ite	-
5	"nat	Completed	15. Decedent's Edu (Specify only highest grad	le completed)		(Give	kind of work done of NOT use retired	during most of wor	rking	TOD. KING	Of Business/III	adstry	
7	withir ene. than he M	m C	Elementary/Secondary (0-12)	College (1-4or 5-	+)		gent	,		Insu	rance C	ompany	
ν 5	filed Hygi sther ent, t		17. Father's Name (First, Middle, Last)				.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	18. Mother's Nar	ne (First, Middle,	Maiden St	urname)		
yland	ld be ental ked c	To Be	William	Earl Bui	.ce				Vera	Mulle	n		
3	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or Items 23a or 28a-f show is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (7)	/pe. Print)	19	9b. Mailir	ng Address (Street	and Number or Ri	ural Route Numb	er, City or 1	Town, State, Zip	Code)	
Z Z	nd 2 alth a 27 is r trai		Norma Jean Selby-B	uice/Wife		5 Apa	ache Cour	t, Gaith	ersburg	, Mary	yland 2	0878	
ກົ	s 1 a of Hea item othe	Ì	20a. Method of Disposition		20b. Place ceme	of Dispo	sition (Name of matory or other place	ce)	Date	20c. Loca	ation - City or To	own, State	
Ē	Page nent c int: if		1 X Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		Union	Cen	netery	1/1	8/2008	Burto	nsville	, MD.	
Dallimo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time ZT is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	-	21 Schature of Funeral Service Licens	See A O	00	22	2. Name and Addre						
0	9 9 E 8 9		Muchal	ale	XX		East De				burg, M		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused one cause on each lin	the death. Do	o not ent	er the mode of dyir	ıg, such as cardia	c or respiratory a	rrest,		Approximate Interval Betweer Onset and Deatl	1 h
	Physician		Immediate Cause (Final disease or condition	a Malignar	it Mela	noma	ı				1	Original Deal	
Æ.	/Medical		resulting in death)	Due to (or as									
	Examiner		Sequentially list conditions, if any, leading to immediate	b		0							
*	pe tis	ine	if any, leading to immediate Cause Enter Underging Cause (Disease or injury	Due to (or as	a consequenc	e or):							
_	and I-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequenc	e of):							
0/0/2	icate be executed physician and s the burial-transit	alE											
200	ficate phys s the	edical		d									
ROX	leath certific attending p I for use as t	Ŋ.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7e			23	d. Date of deliv	ery	
ă	death e atten ed for u	iciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 4 ☐ Pregnant at			⊒Ectopic pregnanc ⊒Other <i>(sp</i> ec <i>ify)</i> _	/			Month	Day Year	
j.	the y th	Physician/Me	9 Unknown	9□Unknown					1				
ν, J	requires that een signed b nould be deta	by P	Part II. Other significant conditions co	ontributing to death be	ut not resulting	g in the u	nderlying cause giv	en in Part I.	23e. Did 1			the cause of death	
ğ	w require been sign should b								1 🗆	Yes 2⊠	No 3 ☐ Pro	bably 4 □Unkr	iown
ecord	aw as b	Completed							24a. Was		24b. Were auto	opsy findings avai empletion of cause	lable e of
r	e T e	E O							perfo 1□ Yes	ormed? 2⊠No	death? 1 ☐ Yes		
VIta	sician; Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check onl	one			
or <	Physician; this certific ral director,	To	1 ☐ Yes 2 ☑ No	Hospital:			III 3 DOX		Home 5 🗷 Resi			ify)	
o _	ding Phys h. After this funeral dir		27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		b. Time o Injury	Wor		28d. Describe	how injury	occurred		
<u> </u>	tend leath. tor: / the fi	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	29a Diago of ini	un. At homo	form of	M 1 ☐ reet, factory, office	Yes 2 ☐ No	29f Location /	Stroot and	Number or Ru	al Route Number,	-
DIVISION	or At offer of Direct in by	Certification:	4 ☐ Homicide determined	building, et		, iaiii, si	reet, lactory, office		City or To	wn, State)	Transcr or Tran	ar riodio italina oli	
_	pital ours a eral I		29a. Certifier 1X Certifying Ph	ysician: To the best	of my knowled	dae, deal	th occurred at the ti	me, date and place	ce, and due to the	cause(s) a	and manner as	stated.	
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Medical	(Check only 2 Medical Exam	niner: On the basis o	f examination	and/or in	nvestigation, in my	opinion, death occ	curred at the time	, date and I	place, and due	to the cause(s)	
	ompl	Me	29b. Signature and title of certifier	1/1			29c. Licens	se number		29d. Date	signed (Month	, Day, Year)	
•	4		Menore /	In Ol	2055	· w	U D	64615		Janus	ary 14,	2008	
ret '	8+1		30. Name and address of person who				, Print)						
			Genevieve Wroblews	ki, M.D.,	1355 I	Picc	ard Drive	, Suite	100, Ro	ckvil.	le, Mar	yland 20	850
	Sta		31. Date filed (Month, Day, Year)	29. Registr	ar's Signature	9							
	Registi	ar	JAN 15 200	Bere	15.	4,28	(E)						
DIL	MILITADAY 4 /0	nn4				47							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Eda Terri BLOOM 2008 6:17 A January 13, 4a. Facility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex Months Days Hours 1 □ M 2 💢 F 62 571-66-8380 May 11, 1945 California California Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2X No Potomac Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20854 10400 Windsor View Drive 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Food and Drug 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administration Immunologist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucy Malin Louis Bloom 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10400 Windsor View Drive, Potomac, MD Edward L. Korn, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Judean Memorial Gardens 01/16/08 Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 21. Signature of Funeral Service Licenses 254 Carroll St., NW, Washington, DC shock, or hear failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death 16 Days Immediate Cause (Final Refractory Ventricular Tachycardia disease or condition resulting in death) Due to (or as a consequence of): Years Paroxysmal Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 16 Days S/P Mitral Valve Repair Procedure Due to (or as a consequence of): 4 Days Fungal Sepsis IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cardiogenic Shock/Right Ventricular Failure 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The discretifying Physician: To the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

**Physician** /Medical Examiner 00. death certificate be executed 68760,

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Bloom Division or

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**Physician** 

/Medical

Examiner

Director

Funeral

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Examiner

Be Completed by Physician/Medical

Certification: To

**Funeral** 

Director

2 should be filed within 72 hours after death with the Maryland and Mental Hyglene.
I marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notitied at

Baltimore, Maryland 21215-0036

12 should be fi

permit. Pages 1 and 2 and Department of Health ar Important: If Item 27 Is any Injury or other trauonce.

as signed by the attending nse detached or Attending Physician: after death

State

To the Hospital o within 24 hours aff To the Funeral D

31. Date filed (Month, Day, Year)

JAN 15 2008



296. License number

29d. Date signed (Month, Day, Year) January 13, 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar/MFND#2per/MD1/15/08, BMW, McCo. Certificate of Death Reg. No. 2. Date of DeathJan. 11, 2008 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Month OAIV BESS 45 AN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** VILW NUTSI air Z Age (In yrs. last birthday) If Under 24 H 5. Social Security Number 6 Sex If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreig Country) 1 M 2 XF 234-48-8886 76 23, 1931 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Howard Columbia 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12290 Green Meadow Drive, Apt. 405 21044 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc ☐Yes 2 X No Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harless Baker Adella Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21044 Carl F. Bess/Husband 12290 Green Meadow Drive, Apt. 405, Disposition (Name of Date 2 /c. Location - Cit Columbia, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 2 c. Location - City or Town, State Jan. 16, Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 2008 Rockville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 23a Pert1. Enter the disease, or complications that caus id the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Silver Spring MD 20901 ory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYGCARDIAL 2NPARCTION TWO Due to (or as a consequence of): NOIZNATIASA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exam Due to (or as a consequence of): Physician/Medical

**Physician** /Medical **Examiner** 

**Funeral** 

Director

? Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Modical Examinar mast be notilized at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be nent of Health and Mental

Health tem 27

perrit. Pag Dep riment Important; if any injury o Irtment

other

The law requires that the death certificate be executed sician and burial-trans the esn signed by the a peen page Physician: funeral After To the Hospital or Attending death. after death Director: filled in by the

Completed by

Medical Certification: To Be

2

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Division of Vital Records, P.O. Box 68760,

F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	
	s contributing to death but not resulting in くら DEMENTA	n the underlying cause giver	n in Part I.
NON . ANSULIN	DEPENDANT	DIABBTES	MELL

 	23d. Da M	ate of de	elivery Day	Year
23e. Did tobacc	o use con	tribute i	to the cau	se of death?
1 □ Yes	2 No	3 □ P	robably	4 ∏Unknown

1749

1	1 Yes 2	ON	3 [] P10	равіу
>	24a. Was an autopsy performed?	24b.	Were autoprior to codeath?	mple

24b.	Were aut	opsy findings ava	ilable e of
	death? 1 ☐ Yes	2 0 No	

5. Was case referred to medical	26. Place of Death (Check only one)				
examiner?	Hospital: 1 ☐ Inpatient 2 ☐		DOA Other:	4 Nursing Home	5 Residen
7. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d.	Describe how
2 Accident investigation		M	1 🗆 Yes	2 □ No	

<b>⊕</b> Γ:	4 Nursing	Home	5 Residence	6 Other (Specify)
y at			Describe how inju	

3 Suicide	6 Could not be	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number,
4 Homicide	determined		City or Town, State)
29a. Certifier	1 Certifying Physi	cian: To the best of my knowledge, death occurred at the time, dat	e and place, and due to the cause(s) and manner as stated

29a. Certifier (Check only one)	1 ☐ Certifying Physici 2 ☐ Medical Examiner	an: To the best of my knowledge, death occu : On the basis of examination and/or investigation and manner stated.	rred at the time, date and place, and due to thation, in my opinion, death occurred at the time	e cause(s) and manner as stated.  b, date and place, and due to the cause(s)
20h Signature and	d title of certifier	^	29c License number	20d Data signed (Month Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. B. VEL (ANK) 8850 COLUMBIA 100 N.B. VELCANKE,

State Registrar

31. Date filed (Month, Day, Year) JAN 15 2008



DHMH 17 Rev 1/2001

24 hours a

within 2 To the

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 8:00 aM Benjamin Eli Becker January 13 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 New York 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1X M 2 D F Yrs. Director 578-34-0350 92 May 28, 1915 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notifled at 1 ☐ Yes 2 No Director Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. death y 5630 Wisconsin Avenue, #203 20815 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1937 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any finury or other thaumatic event, the Medical Examiner. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Self Employed Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Becker P Esther Meyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian N. Becker/ Wife 5630 Wisconsin Avenue, #203, Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens : 01/15/2008 Olney, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Respiratory Failure Days resulting in death) /Medical Due to (or as a consequence of): Examiner Lung Cancer Months Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and dedetached for use as the burial-transit Lymphoma Years Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dehydration 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Acute Renal Failure 24a. Was an has performed' To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate C. Difficile Colitis 1∐ Yes 2⊠No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 🔼 Inpatient 2 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

Registrar

3altimore, Maryland 21215-0036

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P.O. Box 68760

vision or Vital Records,

31. Date filed (Month, Day, Year) JAN 15 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

William F. Simonds, M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814 Registrar's Signature 32

DHMH 17 Rev 1/2001

29c. License number

D36520

29d. Date signed (Month, Day, Year)

January 13, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Norbert J. Bates /Medical January 8. 2008 11:00 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sev Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 ☐ F Yrs Director 210-01-1260 92 Oct. 27, 1915 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. ō 12903 Ardennes Avenue Funeral 20851 - 1907 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 t∑Yes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 🔀 No Specify Specify: White ğ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Babcock & Wilcox Elementary/Secondary (0-12) College (1-4or 5+) Metallurgical Engineer Nuclear Power Division 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Florence Bates Mary Franz 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau James E. Bates - Son 12903 Ardennes Avenue, Rockville, Maryland 20851-1907 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 1/17/2008 Brentwood, Maryland 21. Signature of Fundral Service Licensee 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) **Physician** Pneumonia 2 days /Medical Due to (or as a consequence of): **Examiner** Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 10 years Examiner Due to (or as a consequence of) Congestive Heart Failure Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?

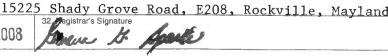
1 Yes 2 No 24a. Was an performed' Vital 2**X** No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other:  ${}_{4}\underline{K}{}_{1}$  Nursing Home  ${}_{5}\Box$  Residence  ${}_{6}\Box$  Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA Certification: To ò 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat e Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a. Certifier 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the I within 24 To the I complet

State

31. Date filed (Month, Day, Year) 2008 JAN 15 Registrar

29b. Signature and title of certifier

Chuanbo Zhang



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D65915

29d. Date signed (Month. Dav. Year)

1/10/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend P1, 27,28a-f, perME, g879 5/13/28 TTFficate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008<sup>Year</sup> JAN. 4, 0436 ALHAJI BAH, Jr 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY Montgomery General Hospital Olney If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 8. Date of Birth (Month, Day, Year) Time 30,1977 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months 1 3M 2 ☐ F Wyoming 30 018-64-5934 Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits MD Gaithersburg 1 ☐ Yes 2 XNo Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20878 U.S.A. 409 Palm Spring Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Staples yr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacqueline Parrott Alhaji Bah, Sr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Palm Spring Dr, Gaithersburg, MD 20878 Jacqueline Bah (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Parial 2 ☐ Cremation 3 ☐ Removal from State 1/16/08 Sandy Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Memorial Cem 21. Signature of Funeral Service Lice 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville; MD 20850 23a. Part1. Enter the distance, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MP Due to (or as a consequence IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SEIZURE DISORDER LEFT HEMIPARESIS 1 Yes 2 No 3 Probably 4 Unknown FAIWLE TO THRIVE. 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 X Accident 5 ☐ Pending investigation May 11, 2002 unk. AM 1 ☐ Yes 2 👿 No *s*ubject fell 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

**Examiner** requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 Physician:

Physician

/Medical

Examiner

Funeral

**Director** 

show

r than "natural", or Items 23a or 28a-f sh the Medical Examiner must be notified

mportant: If Item 2

Physician

/Medical

burial-tran

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page 2

funeral director,

filled in by the

After this

ed by the a

Physician/Medical Examiner

Completed by

Be

Certification: To

(Check only

29b. Signature and title of certifier

Pages 1 and 2 should be file ment of Health and Mental H ant: If Item 27 Is marked out

at

Director

Funeral

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Completed

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Hospital or Attending

hin 24 hours after death. the Funeral Director; A completely within 7

Registrar

R. Smandunder

29c. License number D53367

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

JANUARY 4th 2008

13411 Lowfield Ter. Germantown, MD

SHYAM SUMPAR RAJAW. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEDIGIAAVENVE, SVINE 117, SILVENSPAINGS, MD: 20902

sidewalk

31. Date filed (Month, Day, Year) **JAN 16** 2008

32. Polistrar's Signature